Systems Unit

INDIANA HEALTH COVERAGE PROGRAMS

Master Report Definitions

1 of 4

LIBRARY REFERENCE NUMBER: SYAP10005
REVISION DATE: JUNE 2003
VERSION 2.2

Library Reference Number: SYAP10005

Document Management System Reference: Master Report Definitions

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	December 2000	All	Total document revision	Charlene Schweikhart
Version 1.1	January 2002	Sections 2, 7, 9	Quarterly updates	Karen Girgis
Version 1.2	June 2002	Section 12	Quarterly updates from CSR # IN012778	Karen Girgis
Version 2.2	June 2003	All	Quarterly updates	Anji Olive

Table of Contents

Section 1: Introduction

Overview

Indiana*AIM* is the system used to process Indiana Health Coverage Programs (IHCP) claims. Indiana*AIM* generates reports about the data processed. Reports are scheduled to run daily, weekly, monthly, quarterly, annually, or on request, depending on the report. System-generated reports have a report number and a report name. The report number consists of a three-character alpha prefix that identifies the functional area the report belongs to. It also has a four-character numeric that identifies the report within the functional area. A one-character alpha suffix identifies whether the report is daily (D), weekly (W), monthly (M), quarterly (Q), annually (A), or on request (R). Multiple reports may contain the same data, in different formats.

The following report definitions were created jointly by the Systems Unit and the subject matter experts at the time the reports were created. As reports are updated, these definitions are updated to reflect the changes.

Each report definition lists the description of information on the report, the purpose of the report, the sort sequence of information on the report, the distribution of the report, and detailed field definitions. The detailed field definition lists the fields on the report, and defines each field. Following each report definition is a sample of the report layout.

Section 2: ADJ Reports

ADJ-0001-D Daily Check Log

Functional Area	Report Number	Job Name	Report Title
Adjustments/Financial	ADJ-0001-D		Daily Check Log

Description of Information

The Daily Check Log lists all checks received and entered daily.

Purpose

This report controls and tracks all checks received by EDS, regardless of source. The Daily Check Log report lists all checks received daily, and is used by EDS to maintain positive control over cash receipts.

Sort Sequence

- *Primary -* Check control number (CCN), ascending

Distribution

To	Media	Copies	Frequency
EDS	AIM Financial Windows /Paper	1	Daily

Detailed Field Definitions

Check Number	The printed sequence bank number on the check
Payor Name	The name of the payor on the check
Check Amount	The dollar amount of the check
CCN	It is a unique identifier assigned at the time of receipt. The internal number used for online tracking
Lockbox	The total number of lockbox checks received
SURS	The total number of checks received by SURS
Drug Rebate	The total number of checks received by Drug Rebate
EDS Checks	The total number of EDS checks received
RTS Checks	The total number of RTS checks received
Total	The sum total of all checks which were received and logged by all areas

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```
REPORT: ADJ-0001-D                                              INDIANAAIM                                          RUN DATE: MMDDCCYY
PROCESS:                                                     DAILY CHECK LOG                                        RUN TIME: HH:MM:SS
LOCATION:                                              PERIOD: MMDDCCYY - MMDDCCYY                                        PAGE: 99,999

                        CHECK NUMBER                  PAYOR NAME                  CHECK AMOUNT            CCN
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                         999999999        XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX      999,999,999.99       99999999999
                     TOTAL                                                      9,999,999,999.99


                     MAILROOM                   999
                     SURS                       999
                     PR RELATIONS               999
                     TPL                        999
                     MISC                       999
                     TOTAL                    9,999
                    ______________________________________   ______________________________________
                     ICC                             DATE     CASH EXAMINER                   DATE



                                                         * * END OF REPORT * *


                                                        * * NO DATA THIS RUN * *
```

ADJ-0002-D Daily Deposit Log

Functional Area	Report Number	Job Name	Report Title
Adjustments/Financial	ADJ-0002-D		Daily Deposit Log

Description of Information

The Daily Deposit Log summarizes the total number of checks and the total dollar amount to be deposited for each batch number. The report also calculates the total daily deposit amount.

Purpose

The Daily Deposit Log is an internal report used to itemize the dollar amount of all checks deposited. It is also used by EDS to validate that the bank deposit is equal to the internal deposit log for bank reconciliation.

Sort Sequence

- *Primary* - Batch number, ascending

Distribution

To	Media	Copies	Frequency
EDS	AIM Financial Windows /Paper	1	Daily

Detailed Field Definitions

Batch Number	This number identifies the batch number of the checks deposited. A batch number is assigned to each specific type of check received. (Refer to batch range table)
Number Of Checks Deposited	Indicates how many checks for deposit are a specific batch number.
Dollar Amount Deposited	Indicates the total dollar amount for deposited for each batch range.

REPORT: ADJ-0002-D
PROCESS:
LOCATION:

INDIANA*AIM*
DAILY DEPOSIT LOG
Period: MMDDCCYY - MMDDCCYY

RUN DATE: MMDDCCYY
RUN TIME: HH:MM:SS
PAGE: 99,999

BATCH NUMBER	NUMBER OF CHECKS	AMOUNT DEPOSITED
999	999	999,9,99,999.99
999	999	999,9,99,999.99
999	999	999,9,99,999.99
999	999	999,9,99,999.99
999	999	999,9,99,999.99
999	999	999,9,99,999.99
999	999	999,9,99,999.99
999	999	999,9,99,999.99
TOTAL	9,999	99,999,9,99,999.99

* * END OF REPORT * *

* * NO DATA THIS RUN * *

ADJ-0003-D Daily Cash Control Balance

Functional Area	Report Number	Job Name	Report Title
Adjustments/Financial	ADJ-0003-D		Daily Cash Control Balance

Description of Information

The Daily Cash Control Balancing report is a daily internal report which identifies differences between the total of all check receipt logs and the total number of deposited checks.

Purpose

EDS used this report to identify any discrepancies between the number of checks received and the number of checks deposited. If a variance exists, the checks that were not deposited are listed by CCN with an explanation of why they were held out.

Sort Sequence

- *Primary -* Check control number (CCN), ascending

Distribution

To	Media	Copies	Frequency
EDS	AIM Financial Windows /Paper	1	Daily

Detailed Field Definitions

All Checks Logs	Indicates the total number of checks received as stated on the departmental check logs.
Deposits	Indicates the total number of checks deposited for the day.
Variance	Calculates the difference between the number of checks logged and entered into Indiana*AIM*, and the number of checks deposited at the bank.
CCN	Unique control number given to each check received. The batch number within the CCN indicates the type of check received.
Explanation	A brief explanation why the check was not deposited.

REPORT: ADJ-0003-D
PROCESS:
LOCATION:

INDIANA*AIM*
CASH CONTROL BALANCE REPORT
PERIOD: MMDDCCYY - MMDDCCYY

RUN DATE: MMDDCCYY
RUN TIME: HH:MM:SS
PAGE: 99,999

CHECK RECEIPTS	999
DEPOSITS	999
VARIANCE	9,999

	CCN	EXPLANATION
1.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
2.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
3.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
4.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
5.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
6.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
7.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
8.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
9.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
10.	99999999999	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

CASH CONTROL CLERK DATE

ADJ/CASH CONTROL SPR DATE

* * END OF REPORT * *

* * NO DATA THIS RUN * *

ADJ-2000-D Adjustment Inventory

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2000-D		Adjustment Inventory

Description of Information

The adjustment inventory report summarizes total adjustments entered into inventory (initiated), returned to the sender, and finalized with a beginning and ending balance calculated daily. It also reports adjustments released into the claims processing cycle during the current daily claims cycles. It breaks down this data by claim type and region, with totals for each claim type and summary totals for all claim types.

Purpose

This report is used by EDS in conjunction with the Aged Adjustment Analysis and Cycle Time Compliance reports to monitor and control adjustment inventory, ensuring that all adjustments are processed promptly. It also supplies EDS with the data to track inventory trends as necessary.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Daily
IFSSA	Paper/CRLD	2	Daily

Detailed Field Definitions

CT	The unique code assigned to a claim type. This report displays inventory data for each claim type individually with totals by claim type. This report also summarizes all claim types and their totals.
Desc	The complete name of the claim type
Beginning Inventory	The beginning adjustment inventory. This is carried from the ending inventory of the previous week's report. Initial beginning inventory for the first claims cycle is the total of all adjustment suspense that is converted from the MMIS system, regions 45 and 46 only. All other regions will be zero.

Adj Initiated	The number of adjustments logged into inventory during the current daily cycle. This is obtained by counting all ICNs entered into the adjustment inventory table, region 50, and a count of all cash receipts dispositions entered with a refund adjustment reason code of 8040-8079 or 8160-8199, region 51. For regions 54-57, mass adjustments, report a count of all adjustment claims released into the weekly cycle for processing. These are started immediately by the system.
Adj RTS	The number of adjustment requests logged as returned to the sender or mis-batched during the daily adjustment cycle. This data is obtained from the adjustments return to sender table. There will be no RTS data for regions 54-57.
Adj Finalized	The number of adjustments reported for all regions adjudicated to final *approved to pay* or *deny* status, locations 97, 98, or 66, during the daily cycle.
Ending Inventory	The ending inventory as calculated at the end of each daily cycle, calculated as follows: (Beginning Inventory + Adjustments Initiated) - (Adj RTS + Adj Finalized) = Ending Inventory
Adj. Released	This field is for informational purposes only and does not affect the calculations in this report. It states the number of adjustments by claim type and region that were released *production released* for processing into the Indiana*AIM* system during the daily cycle.

Report: ADJ-2000-D Indiana*AIM* *Date: MMDDCCYY*
Process: ADJUSTMENT INVENTORY *Time: HH:MM:SS*
Location: Period: MMDDCCYY-MMDDCCYY *Page: 99,999*

CT	DESC	BEGINNING INVENTORY	ADJ INITIATED	ADJ RTS	ADJ FINALIZED	ENDING INVENTORY	ADJ RELEASED
A	UB92 INST XOVER CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
B	HCFA 1500 XOVER CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
C	UB92 OUTP XOVER CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999

Report: ADJ-2000-D Indiana*AIM* *Date: MMDDCCYY*
Process: ADJUSTMENT INVENTORY *Time: HH:MM:SS*
Location: Period: MMDDCCYY-MMDDCCYY *Page: 99,999*

CT	DESC	BEGINNING INVENTORY	ADJ INITIATED	ADJ RTS	ADJ FINALIZED	ENDING INVENTORY	ADJ RELEASED
D	DENTAL CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
F	FINANCIAL						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
H	HOME HEALTH CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999

Report: ADJ-2000-D — Indiana*AIM* — *Date: MMDDCCYY*
Process: — ADJUSTMENT INVENTORY — *Time: HH:MM:SS*
Location: — Period: MMDDCCYY-MMDDCCYY — *Page: 99,999*

CT	DESC	BEGINNING INVENTORY	ADJ INITIATED	ADJ RTS	ADJ FINALIZED	ENDING INVENTORY	ADJ RELEASED
I	INPATIENT CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
L	LONG TERM CARE CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
M	HCFA 1500 CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999

Report: ADJ-2000-D — Indiana*AIM* — *Date:* *MMDDCCYY*
Process: — ADJUSTMENT INVENTORY — *Time:* *HH:MM:SS*
Location: — Period: MMDDCCYY-MMDDCCYY — *Page:* *99,999*

CT	DESC	BEGINNING INVENTORY	ADJ INITIATED	ADJ RTS	ADJ FINALIZED	ENDING INVENTORY	ADJ RELEASED
O	OUTPATIENT CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
P	PHARMACY CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
Q	COMPOUND DRUG CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999

Report: ADJ-2000-D Indiana*AIM* *Date: MMDDCCYY*
Process: ADJUSTMENT INVENTORY *Time: HH:MM:SS*
Location: Period: MMDDCCYY-MMDDCCYY *Page: 99,999*

CT	DESC	BEGINNING INVENTORY	ADJ INITIATED	ADJ RTS	ADJ FINALIZED	ENDING INVENTORY	ADJ RELEASED
S	SHADOW CLAIMS						
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999
TOTAL	ALL CLM TYPES	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 45	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 46	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 50	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 51	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 54	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 55	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 56	999,999	999,999	999,999	999,999	999,999	999,999
	REGION 57	999,999	999,999	999,999	999,999	999,999	999,999
	TOTAL	999,999	999,999	999,999	999,999	999,999	999,999

* * END OF REPORT * *

ADJ-2001-W Aged Adjustment Listing - by User ID

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2001-W		Aged Adjustment Listing - by User ID

Description of Information

The Aged Adjustment Listing - by User ID lists all outstanding adjustments by user in aged and claim type order.

Purpose

This report allows EDS adjustment analysts and their supervisor to maintain positive control over aging adjustments by identifying the oldest claims for priority resolution.

Sort Sequence:

- *Primary* - UserID, ascending
- *Secondary* - Days aged, descending
- *Tertiary* - Claim type, ascending
- *Fourth* - ICN, descending

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Weekly

Detailed Field Definitions

C/T	The claim type of the aged adjustment claim.
ICN	The internal control number (ICN) of the aged adjustment claim.
RID No	The recipient's identification number associated with the aged adjustment claim.
Bill Prov	The assigned billing provider associated with the aged adjustment claim.
Elsp Days	The number of days the adjustment claim has aged.
Loc Cd	The latest occurring location code of the aged adjustment claim.
Loc Dt	The latest occurring date on which the claim entered a location.
Days	The number of days the claim has been in the current location.
User ID	The assigned number identifing the clerk who initiated the adjustment claim.
Total No. Aged Adjustments	The total number of adjustments reported on the aged listing for a specific clerk ID.

NOTE: This report starts a new page for each new User ID encountered.

```
Report:  ADJ-2001-W                                      IndianaAIM                                             Date: MMDDCCYY
Process:                                           AGED ADJUSTMENT LISTING                                     Time:  HH:MM:SS
Location:                                                BY User ID                                               age:  99,999
                                                  Period: MMDDCCYY-MMDDCCYY

    C/T          --ICN--               RID No.         BILL PROV   ELSP DAYS   LOC CD     LOC DT    DAYS     USER ID

     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX
     X        RRYYJJJBBBSSS         999999999999      999999999X     9,999       XX       MMDDYY    9,999    XXXXXXXX

USER ID  XXXXXXXX     TOTAL NO. AGED ADJUSTMENTS  99,999


                                            * * * PAGE BREAK AT NEW CLERK ID * * *
```

ADJ-2003-W Aged Active Claim Analysis - Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2003-W		Aged Active Claim Analysis - Adjustments

Description of Information

This report lists the previous, current, and average number of days in each category, as well as the current balance. There are six time segments ranging from zero to 91+ days. The information on this report pertains to adjustment claims only.

Purpose

Sort Sequence

- *Primary* - Claim type, descending
- *Secondary* - Location code, ascending

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Weekly
IFSSA	Paper/CRLD	2	Weekly

Detailed Field Definitions

Claim Type

This is the one-byte field representing claim type. Valid values are as follows:

A = Crossover Part A
B = Crossover Part B (Medical)
C = Crossover (Outpatient)
D = Dental
H = Home Health
I = Inpatient
L = Long Term Care
M = CMS 1500
O = Outpatient
P = Pharmacy

Desc.

Description of the claim type indicator.

Location Code

The 15-byte alpha/numeric field containing the location of the claim and its two-byte alpha/numeric code. Valid values are as follows:

00 - Validation
01 - Provider
02 - Recipient
03 - Prior Auth
04 - Reference
20 - History
21 - Medical
30 - SURS
40 - CCF
41 - Recycle
42 - Hold
43 - IFSSA
44 - CSCHS
90 - Special Handling
PP - Production Adjustment Pending Release
PR - Production Adjustment Released

Current Bal

The total number of claims suspended in each location.

N-N Days Count

The total number of claims suspended in this location for *n-n.*

N-N Days %

The percentage of claims suspended in this location. The percentage is calculated as follows:

$$\frac{\textit{n-n}\text{ Day Count}}{\text{Location x Current Balance}}.$$

Sub Total Current Bal

The total number of claims suspended for all locations in the above claim type.

Subtotal Count N-N

The total number of claims suspended for all locations in the above claim type.

Subtotal Pct N-N Days

The percentage of claims suspended for all locations in the above claim type. The percentage is calculated as follows:

$$\frac{\text{Subtotal }\textit{n-n}\text{ Day Count}}{\text{Subtotal Current Bal}}$$

Total Location X Current Bal

The total number of claims suspended in this location for all claim types.

Total Location X N-N Day Count

The total number of claims suspended to this location for the displayed number of days for all claim types.

Sub Total Location X Pct	The percentage of claims suspended to this location for all claim types. The percentage is calculated as follows: Total Location *n-n* Day Count Total Location X Current Bal
Grand Total N-N Days Count	The total number of claims suspended in all locations for all claim types.
Grand Total N-N Days Pct	The percentage of claims suspended in all locations for all claim types. The percentage is calculated as follows: Grand Total *n-n* Day Count Grand Total Current Bal

Report: ADJ-2003-W **Indiana*AIM*** *Date: MMDDCCYY*
Process: **AGED ACTIVE CLAIM ANALYSIS** *Time: HH:MM:SS*
Location: **ADJUSTMENTS** *Page: 99,999*
Period: MMDDCCYY-MMDDCCYY

CLAIM TYPE: X DESC: XXXXXXXXXXXXXXXXXXX

	CURRENT	0-15 DAYS		16-30 DAYS		31-45 DAYS		46-60 DAYS		61-90 DAYS		91-365 DAYS		365+ DAYS	
LOCATION CODE	BAL	COUNT	%	COUNT	%	COUNT	%	COUNT	%	COUNT	%	COUNT	%	COUNT	%
00-VALIDATION	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
01-PROVIDER	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
02-RECIPIENT	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
03-PRIOR AUTH	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
04-REFERENCE	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
20-HISTORY	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
21-MEDICAL	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
30-SURS	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
41-RECYCLE	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
42-HOLD	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
43-IFSSA	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
44-CSHCS	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
90-SPECIAL HANDLING	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
PP-ADJ PENDING	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
PR-ADJ RELEASE	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
SUBTOTAL	999999	99999	99.99	99999	99.99	99999	99.99	99999	99.99	99999	99.99	99999	99.99	99999	99.99

CLAIM TYPE: X DESC: XXXXXXXXXXXXXXXXXXX

LOCATION CODE	CURRENT BAL	0-15 DAYS COUNT	%	16-30 DAYS COUNT	%	31-45 DAYS COUNT	%	46-60 DAYS COUNT	%	61-90 DAYS COUNT	%	91-365 DAYS COUNT	%	365+ DAYS COUNT	%
00-VALIDATION	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
01-PROVIDER	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
02-RECIPIENT	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
03-PRIOR AUTH	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
04-REFERENCE	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
20-HISTORY	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
21-MEDICAL	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
30-SURS	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
41-RECYCLE	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
42-HOLD	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
43-IFSSA	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
44-CSHCS	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
90-SPECIAL HANDLING	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
PP-ADJ PENDING	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
PR-ADJ PENDING	9999	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99	9999	99.99
SUBTOTAL	999999	99999	99.99	99999	99.99	99999	99.99	99999	99.99	99999	99.99	99999	99.99	99999	99.99
GRAND TOTAL ALL C/T	9999999	999999	999.99	999999	999.99	999999	999.99	999999	999.99	999999	999.99	999999	999.99	999999	999.99

ADJ-2004-W EOB Denial Analysis List - Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2004-W		EOB Denial Analysis List - Adjustments

Description of Information

The report lists the error code, description, and the Explanation of Benefits (EOB) posted to the claim when it denied. The total number of denials for each error code and the number of denials per claim type are reported in the claim type columns. At the end of the report, the grand total number of auto denials and manual denied claims is calculated. This report only counts denied adjustment claims.

Purpose

The EOB Denial Analysis List report is used by EDS and IFSSA to identify the number of adjustment claims that auto-denied and manually denied in the current weekly claims cycle. The error status codes (ESC) which cause claims to be auto-denied are in the Edit/Audit Disposition Table. ESCs which cause claims to be manually denied are set to suspend in the Error Disposition Table.

Sort Sequence

- *Primary* - ESC, ascending
- *Secondary* - EOB, descending

> *Note: This report has a section break between auto denied claims and manually denied claims.*

Distribution

To	Media	Copies	Frequency
IFSSA	Paper/CRLD	2	Weekly
EDS	Paper/CRLD	1	Weekly

Detailed Field Definitions

ESC	The four-byte error status code which caused at least one claim to auto-deny during the current processing cycle.
Desc.	The description of the four-byte error status code
EOB	The four-byte Explanation of Benefit code assigned to the ESC when it is set to auto-deny.
Total	The number of times that this ESC auto-denied during the current processing cycle (all claim types).
Pharm	The total number of times that this error status code auto-denied for pharmacy claims.

Med	The total number of times that this error status code auto-denied for medical claims.
Dent	The total number of times that this error status code auto-denied for dental claims.
Inpat	The total number of times that this error status code auto-denied for inpatient claims.
Outp	The total number of times that this error status code auto-denied for outpatient claims.
LTC	The total number of times that this error status code auto-denied long term claims.
H Hlth	The total number of times that this error status code auto-denied for home health claims.
Xovr	The total number of times that this error status code auto-denied for crossover claims.
Total Errors	The number of auto-denials for all the error status codes during the current processing cycle for all claim types, sorted by claim type.
ESC	The four-byte error status code associated with the manual denial. ESCs set to suspend on the error disposition table require manual examination of the claim. Claims are checked for validity and completeness. If the claim does not meet the criteria of the ESC, it may result in the manual denial of the claim.
Desc	The description of the four-byte ESC.
EOB	The four-byte Explanation of Benefit code assigned to the ESC.
Total	The number of times that this ESC manually denied during the current processing cycle for all claim types.
Pharm	The total number of times that this error status code manually denied for pharmacy claims.
Med	The total number of times that this error status code manually denied for medical claims.
Dent	The total number of times that this error status code manually denied for dental claims.
Inpat	The total number of times that this error status code manually denied for inpatient claims.
Outp	The total number of times that this error status code manually denied for outpatient claims.
LTC	The total number of times that this error status code manually denied long term care claims.
H Hlth	The total number of times that this error status code manually denied for

	home health claims
Xovr	The total number of times that this error status code manually denied for crossover claims.
Total Errors	The number of manual denials for all error status codes during the current processing cycle for all claim types, sorted by claim type.
Grand Total	The number of manual and auto-denials during the current processing cycle for all claim types, sorted by claim type

.

```
Report:  ADJ-2004-W                                  IndianaAIM Date:  CCYYMMDD
Process:                                      EOB DENIAL ANALYSIS LIST                                          Time:  HH:MM:SS
Location:                                           ADJUSTMENTS                                                     Page:  99,999
                                            Period:  CCYYMMDD - CCYYMMDD

                                                   AUTO DENIED CLAIMS

ESC    DESC                           EOB   TOTAL  PHARM   MED   DENT    INPAT   OUTP   LTC   HLTH   XOVR

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

TOTAL ERRORS AUTO DENIED                    99999   9999   9999   9999   9999   9999   9999   9999   9999

                                                  MANUALLY DENIED CLAIMS

ESC    DESC                           EOB   TOTAL  PHARM   MED   DENT    INPAT   OUTP   LTC  H HLTH  XOVR

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

9999  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999   9999   9999   9999   9999   9999   9999   9999   9999   9999

TOTAL ERRORS MANUALLY DENIED                99999   9999   9999   9999   9999   9999   9999   9999   9999

GRAND TOTAL ERRORS DENIED                   99999   9999   9999   9999   9999   9999   9999   9999   9999

                                                       END OF REPORT
```

ADJ-2005-W Edit/Audit Override Analysis - Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2005-W		Edit/Audit Override Analysis - Adjustments

Description of Information:

This report is an analysis of all adjustment overrides, by user ID. It indicates which errors were overridden and the number of claims overridden for a specific adjustment analyst, sorted by claim type.

Purpose

The report is used by EDS and IFSSA to identify which error codes are being overridden. It aids in monitoring the frequency of which errors are overridden and by whom.

Sort Sequence

- *Primary* - User ID, ascending
- *Secondary* - Claim type, ascending
- *Tertiary* - ESC, ascending

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	0	Weekly
IFSSA	Paper/CRLD	0	Weekly

Detailed Field Definitions

User ID — The eight-byte user ID of the Adjustments clerk who overrode the error status code listed. Print only the first occurrence of each user ID.

CT — The one-byte claim type indicator. Valid values are as follows:

D = Dental
L = Long Term Care
M = CMS 1500
I = Inpatient
O = Outpatient
P = Pharmacy
X = Crossover A, B, and C

ESC — The four-byte error status code associated with the override. Only Error Status Codes that are overridden at least once are displayed.

Desc ESC	A brief description of the error status code.
Num Of Claims	The number of claims overridden for a specific error status code for the particular user ID.
Total Overrides	The total number of claims overriden for all user IDs and all error status codes.

```
Report:  ADJ-2005-W        IndianaAIM                   Date:  CCYYMMDD
Process:                                         EDIT/AUDIT OVERRIDE ANALYSIS                                   Time:  HH:MM:SS
Location:                                                ADJUSTMENTS                                              Page:  99,999
                                                 Period:  CCYYMMDD - CCYYMMDD


                                 USER ID              CT              ECS             NO. CLAIMS

                                XXXXXXXX              X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                  TOTAL                                                999999

                                XXXXXXXX              X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                  TOTAL                                                999999

                                XXXXXXXX              X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                                      X               9999              99999
                                  TOTAL                                                999999

                                   TOTAL OVERRIDES                                     999999
```

ADJ-2006-W Adjustments - Return to Sender Log

Functional Area	Report Number	Job Name	Report Title
Adjustments/Financial	ADJ-2006-W		Cash Receipts Return to Sender Log

Description of Information

The Return to Sender Log lists all adjustment ICNs and CCNs returned weekly.

Purpose

This report is used by EDS as a monitoring and control report for all returned documentation and request for additional documentation or information.

Sort Sequence

- *Primary* - Provider number, ascending
- *Secondary* - Date returned, ascending
- *Tertiary* - Adjustment ICN or CCN, ascending

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Weekly

Detailed Field Definitions

Date Received	Date of cash receipt as indicated by the Year and Julian Date of the cash control number.
Date Returned	Date logged for return to sender as stated on the Return to Sender audit table.
Provider Number	The provider as stated on the Return to Sender table, if applicable. This field is not required.
Sender Name	Name of sender as entered in the Return to Sender table.
Adj ICN	The unique internal control number assigned to the adjustment request. This number identifies the year, date, and claim type.
CCN	The unique cash control number assigned to the cash receipt. This number identifies the year, date, and type of check received.
Return Reason	The three-character reason code that identifies why the check was received. Valid value range: R00-R19
User ID	The unique User ID that identifies who initiated the return to sender action. See audit table.
Total Returns	Indicates the total number of cash receipts received and returned to sender.

```
Report:  ADJ-2006-W                                      IndianaAIM                                        Date:  MMDDCCYY
Process:                                                Adjustments                                        Time:  HH:MM:SS
Location:                                           Return to Sender Log                                     Page:  99,999
                                               Period:  CCYYMMDD - CCYYMMDD

         DATE          DATE      PROVIDER                                                                     RETURN        USER
        RECEIVED     RETURNED     NUMBER             SENDER NAME            ADJ ICN            --CCN--       REASON         ID

         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX
         MMDDYY       MMDDYY    999999999 X    XXXXXXXXXXXXXXXXXXXXXXXXX     RRYYJJJBBBSSS      YYJJBBBSSS      XXX        XXXXXXXX

TOTAL RETURNS:  999,999
```

ADJ-2007-W Analysis by Provider Number - Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2007-W		Analysis by Provider Number - Adjustments

Description of Information

The report lists the top ten provider numbers and the top five Error Status Codes associated with adjustment claims for those providers for a given reporting week.

Purpose

The Error Analysis by Provider Number report is used by EDS to examine the top ten providers who encountered the most errors in the adjustment claims processing system. This report is forwarded to Client Services so they can notify the affected providers of the errors encountered. The primary purpose of this report is provider education.

Sort Sequence

- *Primary -* Provider number
- *Secondary -* ESC

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly
FSSA	CRLD/Paper	2	Weekly

Detailed Field Definitions

Provider No.	The Provider's nine-byte IHCP identification number.
ESC	The four-byte error status code.

```
Report:                                   IndianaAIM                                      Date:  CCYYMMDD
Process:                      ERROR ANALYSIS BY PROVIDER NUMBER                           Time:  HH:MM:SS
Location:                                ADJUSTMENTS                                       Page:  99,999


                              PROVIDER NO.    ESC

                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999
                              999999999      9999  9999  9999  9999  9999

                                          END OF REPORT
```

ADJ-2008-W Error Analysis by Suspended Error Code-Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2008-W		Error Analysis by Suspended Error Code-Adjustments

Description of Information

The report shows the number of adjustment claims by claim type suspended for each edit. All edits suspending are listed under the error number column with a brief description. For each edit a total number of suspensions for each adjustment region is reported with a total number calculated for each claim type. A summary of all regions and a grand total are calculated.

Purpose

The Error Analysis by Error Code report is used by EDS and IFSSA to monitor weekly edit suspensions for each adjustment region. When high edit counts are identified, research is done to determine if edits need revision or if providers are experiencing billing problems. If a provider is identified as having problems, the provider relations area may contact the provider to help alleviate or resolve the problems

Sort Sequence

ESC, ascending

Distribution

To	Media	Copies	Frequency
EDS/IFSSA	CRLD	0	Weekly

Detailed Field Definitions

ESC	The four-byte error status code associated with the suspended error code
Desc	The description of the four-byte ESC
Total	The total number of times that this error status code occurred during the past week for each adjustment region.
Pharm	The total number of times that this error status code occurred for pharmacy claims for each adjustment region.
Med	The total number of times that this error status code occurred for medical claims for each adjustment region.

Dent	The total number of times that this error status code occurred for dental claims for each adjustment region.
Inpt	The total number of times that this error status code occurred for inpatient claims for each adjustment region.
Outp	The total number of times that this error status code occurred for outpatient claims for each adjustment region.
LTC	The total number of times that this error status code occurred for long term care claims for each adjustment region.
HHLTH	The total number of times that this error status code occurred for home health claims for each adjustment region.
XOvr	The total number of times that this error status code occurred for crossover A, B, and C claims combined for each adjustment region.
Grand Total	The total number of times that all error status codes occurred during the current weekly claim cycle for each adjustment region.

```
Report:  ADJ-2008-W                                      IndianaAIM                                            Date:  CCYYMMDD
Process:                                   ERROR ANALYSIS BY SUSPENDED ERROR CODE                              Time:  HH:MM:SS
Location:                                               ADJUSTMENTS                                              Page:  99,999
                                                Period:  CCYYMMDD - CCYYMMDD

ESC   DESC                      REGION      TOTAL  PHARM    MED     DENT    INPT    OUTP    LTC    HHLTH    XOVR
9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                              ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                              ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                              ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                              ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

GRAND TOTALS                      50        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                              ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999
```

ADJ-2009-W Error Analysis by Forced Error Code-Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2009-W		Error Analysis by Forced Error Code-Adjustments

Description of Information

The report lists the error code, its description, and the number of times per claim type that the error was overridden and forced through the system. This is divided by adjustment region code with a total for each error status code.

Purpose

The Error Analysis by Forced Error Code report is used by EDS and IFSSA to monitor the effectiveness of the error codes. It is also used to determine whether error codes are necessary, depending on the volume of claims that are forced to adjudicate and pay.

Sort Sequence

Primary - Error status code, ascending

Distribution

To	Media	Copies	Frequency
EDS/IFSSA	Paper/CRLD	0	Weekly

Detailed Field Definitions

ESC	The four-byte error status code forced through the system during the current weekly claims cycle
Desc	The description of the four-byte ESC
Total	The total number of times that this error status code forced through the system during the past week for each adjustment region.
Pharm	The total number of times that this error status code forced through the system for pharmacy claims for each adjustment region.
Med	The total number of times that this error status code forced through the system for medical claims for each adjustment region.
Dent	The total number of times that this error status code forced through the system for dental claims for each adjustment region.
Inpt	The total number of times that this error status code forced through the system for inpatient claims for each adjustment region.

Outp	The total number of times that this error status code forced through the system for outpatient claims for each adjustment region.
LTC	The total number of times that this error status code forced through the system for long term care claims for each adjustment region.
HHLTH	The total number of times that this error status code forced through the system for home health claims for each adjustment region.
XOvr	The total number of times that this error status code forced through the system for crossover A, B, and C claims combined for each adjustment region.
Grand Total	The total number of times that all error status codes forced through the system during the current weekly claim cycle for each adjustment region.

```
Report:  ADJ-2009-W                                        IndianaAIM                                           Date:  CCYYMMDD
Process:                                      ERROR ANALYSIS BY FORCED ERROR CODE                               Time:  HH:MM:SS
Location:                                                 ADJUSTMENTS                                             Page:  99,999
                                                  Period:  CCYYMMDD - CCYYMMDD

ESC   DESC                      REGION      TOTAL  PHARM    MED     DENT    INPT    OUTP    LTC    HHLTH    XOVR
9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                             ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                             ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                             ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

9999  XXXXXXXXXXXXXXXXXXXXXXXX    50        9999    9999    9999    9999    9999    9999    9999    9999    9999
      XXXXXXXXXXXXXXXXXXXXXXXX    51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                             ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999

GRAND TOTALS                      50        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  51        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  55        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  56        9999    9999    9999    9999    9999    9999    9999    9999    9999
                                  57        9999    9999    9999    9999    9999    9999    9999    9999    9999
                             ALL REGIONS  99999   99999   99999   99999   99999   99999   99999   99999   99999
```

ADJ-2010-W Weekly Claim Adjudication Cycle Time Analysis-Adjustments

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2010-W		Weekly Claim Adjudication Cycle Time Analysis-Adjustments

Description of Information

The report lists adjustment claim counts by claim type and the number of days to reach final status. Final status is reached when claims hit locations: 66-denied, 97-approved to pay (claim payment hold), 98-approved for payment, or 99-paid. This report also lists the percentage of total claim volume by days elapsed and the average age of claims to final status. This report spans a 45-day period which equates to the 45-day requirement to adjudicate 100 percent of all adjustment claims in 45 days.

Purpose

The Weekly Claim Adjudication Cycle Time Analysis-Adjustments report is used by EDS and IFSSA to monitor the adjustment claims processing time to ensure that full cycle time compliance is met.

Sort Sequence

- *Primary* - Claim type, ascending

Distribution

To	Media	Copies	Frequency
EDS/IFSSA	Paper/CRLD	0	Weekly

Detailed Field Definitions

Days — Number of days column. This represents a day of elapsed time for the reporting period

Claim Type

This field represents claim type. Valid values are as follows:

- P=Pharmacy
- M=CMS-1500
- D=Dental
- I=Inpatient
- O=Outpatient
- L=Long term care
- H=Home health
- X=Crossovers A, B, and C

The total claim count and the total percentage of claims are reported for each day of elapsed time. A *G* is printed next to each claim type's percent column on the 45th day of elapsed time to indicate that this is the goal to adjudicate 100 percent of all adjustments. An * is printed next to the percentage column to indicate when 100 percent adjudication actually occurred for that claim type. Claim counts below the asterisked row are always zero.

Totals

The total number of claims processed for each claim type and all claim types during the 45-day reporting period.

Standard

The RFP requires that 100 percent of claims in suspense are processed within 45 days. Excluded from this standard are claims in locations: 21-Medical Policy, 42-Hold, 43-IFSSA, 44-CHSCS, 97-Fiscal Pend. All claim types. Note: Days in these locations are not included in the total number of days in suspense.

Actual

Percent of total volume by claim type that reached final status in 45 days.

Average

The average number of days taken for all claims in each claim type to reach final status during the reporting period.

```
Report:  ADJ-2010-W                                        IndianaAIM                                            Date:  MMDDCCYY
Process:                             WEEKLY ADJUDICATION CYCLE TIME ANALYSIS - ADJUSTMENTS                       Time:  HH:MM:SS
Location:                                         Period:  CCYYMMDD - CCYYMMDD                                     Page:  99,999

DAYS   PHARMACY       HCFA-1500       DENTAL        INPATIENT      OUTPATIENT  LONG TERM CARE   HOME HEALTH     CROSSOVER    ALL CLM TYPES

999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99* 9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99G 9999999 99.99  9999999 99.99* 9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99* 999999999 99.99
999  9999999 99.99  9999999 99.99* 9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99G 9999999 99.99  9999999 99.99  9999999 99.99* 9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99G 9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99* 9999999 99.99* 9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99G 9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99G 9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99G 9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99G 999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99* 9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99G 9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99
999  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  9999999 99.99  999999999 99.99

TOTALS:

    99999999       99999999       99999999       99999999       99999999       99999999       99999999      999999999        9999999999

STANDARD:  100 % IN 45 DAYS
ACTUAL     999.99%        999.99%       999.99%         999.99%         999.99%       999.99%        999.99%         999.99%          999.99%
AVG DAYS:    99.9           99.9          99.9             99.9            99.9         99.9          99.9            99.9             99.9
```

ADJ-2072-W Mass Adjustment Process - LTC Retro Rate Claim Listing

Functional Area	Report Number	Job Name	Report Title
Adjustments	ADJ-2072-W		Mass Adjustment Process - LTC Retro Rate Claim Listing

Description of Information

The Mass Adjustment Process - LTC Retro Rate Claim Listing is produced as both an on-line and CRLD report which lists all voids, retro rates, and mass adjustments which were adjusted during the current weekly cycle. The report is sorted by provider number and lists each claim adjusted for each region, the number of claims adjusted, and the number of providers associated with the claim adjustments.

Purpose

This report is used by EDS and IFSSA to validate all claims processed for each region during the weekly cycle. Client Services and other areas will also have access to this report on-line to aid in resolving retroactive rate adjustment related questions which may arise.

Sort Sequence:

CRLD

- *Primary* - Provider number, ascending
- *Secondary* - Adjustment ICN, ascending

On-line

- *Primary* - Set sort by provider number, ascending
- *Secondary* - Within provider number, sort options include:
  Adjustment ICN
  Original ICN
  Recipient

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly
IFSSA	CRLD/Paper	2	Weekly

Detailed Field Definitions

Indiana Health Coverage Program	The provider's unique assigned number.
Adjustment ICN	The Internal Control Number (ICN) of the adjusted claim, otherwise known as the daughter claim.

Original ICN	The ICN of the original claim, otherwise known as the mother claim.
Provider/Loc	The provider's unique assigned number.
RID No.	The RID number associated with the adjusted claim.
Claim DOS - From	The “from” date of service on the adjusted claim.
Claim DOS - Thru	The “thru” date of service on the adjusted claim.
Original Pd Amount	The original paid amount of the claim.
Adjustment Pd Amount	The new amount of the claim.
Net Adjusted Amount	The difference between the original paid amount and the adjustment paid amount.
Reason Code	Code which explains the reason for the adjustment.
Total # Claims Adjusted	The total number of claims associated with all Long Term Care retroactive rate adjustments for all providers for the current weekly cycle.
Total # Providers	The total number of providers associated with all Long Term Care Retroactive Rate adjustments for all providers for the current weekly cycle.
Total Net Adjusted Amount	The total of all net adjusted amounts for the current weekly cycle.

```
REPORT:  ADJ-2072-W                                        INDIANAAIM                                         DATE:  MM/DD/CCYY
PROCESS:                                     MASS ADJUSTMENT PROCESS CLAIM LISTING                              TIME:  HH:MM:SS
LOCATION:                                       PERIOD: MM/DD/CCYY - MM/DD/CCYY                                   PAGE:  99,999

INDIANA HEALTH COVERAGE PROGRAM:  XXXXXXXXXXXXXXXXXXXXXXXX

REGION 54
                                                          --CLAIM DOS--       ORIGINAL     ADJUSTMENT    NET ADJUSTED  REASON
ADJUSTMENT ICN  ORIGINAL ICN  PROVIDER/LOC    RID NO.    FROM         THRU    PD AMOUNT    PD AMOUNT      AMOUNT       CODE

 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999

TOTAL # CLAIMS ADJUSTED  999,999                                             TOTAL NET ADJUSTED AMOUNT  99,999,999.99
TOTAL # PROVIDERS  999,999


REGION 55

 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999

TOTAL # CLAIMS ADJUSTED  999,999                                             TOTAL NET ADJUSTED AMOUNT  99,999,999.99
TOTAL # PROVIDERS  999,999


REGION 56

 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999

TOTAL # CLAIMS ADJUSTED  999,999                                             TOTAL NET ADJUSTED AMOUNT  99,999,999.99
TOTAL # PROVIDERS  999,999
```

```
REGION 57

 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999
 RRYYJJJBBBSSS  RRYYJJJBBBSSS  999999999 A  999999999999  CCYYMMDD CCYYMMDD  9,999,999.99  9,999,999.99  9,999,999.99   9999

TOTAL # CLAIMS ADJUSTED  999,999                                              TOTAL NET ADJUSTED AMOUNT  99,999,999.99
TOTAL # PROVIDERS  999,999



                                   * * PAGE BREAK AT NEW INDIANA HEALTH COVERAGE PROGRAM * *
```

```
REPORT:  ADJ-2072-W                    INDIANAAIM                    DATE:  MM/DD/CCYY
PROCESS:                      MASS ADJUSTMENT PROCESS CLAIM LISTING    TIME:  HH:MM:SS
LOCATION:                        PERIOD: MM/DD/CCYY - MM/DD/CCYY       PAGE:  99,999

                                    GRAND TOTALS


                              TOTAL NUMBER OF CLAIMS  999,999
                              TOTAL NUMBER PROVIDERS  999,999
                          TOTAL NET ADJUSTED AMOUNT  999,999,999.99


                                  * * END OF REPORT * *

                                 * * NO DATA THIS RUN * *
```

Section 3: AVR Reports

AVR-0001-D Daily Call Statistics Hourly Summary

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response l	AVR-0001-D		Daily Call Statistics Hourly Summary

Description of Information

The Daily Call Statistics Hourly Summary (AVR-0001-D) report is sorted by hour and lists the total number of Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions for the time period. The report includes total counts for caller hang-ups, provider-reached maximum number of transactions, host down, or provider-reached maximum number of errors for the time period.

Purpose

EVS uses the Daily Call Statistics Hourly Summary Report (AVR-0001-D) to identify peak hours of operation, average duration and transactions per call, types of calls, and call end reasons.

Sort Sequence

- *Primary* - Time period

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Daily

Detailed Field Definitions

Time Period	Indicates the hour of the day that the data represents.
Num Txns	Indicates the total number of transactions performed during the calls made to the VRS during the time period.
Average Per Call:	
Call Duration	The average length of time for phone calls during the time period. The average call duration time is calculated by dividing the total duration of all calls for the time period by the total number of calls for the time period. Call Duration= Total duration of all calls / num calls
Host Rsp Time	The average time the VRS takes to respond to a request or inquiry. This

time is calculated by dividing the total time the host takes to respond to all inquires (transactions) for the time period by the total number of calls for the time period. Host Rsp Time = $\frac{\text{Total length of host response time}}{\text{num calls}}$

Num Txns

The average number of transactions made for the time period. The average number of transactions is calculated by dividing the total number of transactions made for the time period by the total number of calls for the time period. by the total number of calls for the time period.

Num Txns = $\frac{\text{Total number of transactions}}{\text{num calls}}$

Num Errs

The average number of errors encountered by the VRS for the time period.

Host Timeouts

The host computer is allowed three time-outs (ten seconds each) to respond to a transaction. If the host does not respond after the third time-out, or if an error occurs during the processing of the transaction, the system terminates the call.

User Timeouts

The user is allowed two user time-outs (10 seconds each) to enter the requested data. On the first time-out, the system prompts the user for the required data. On the second time-out, the system terminates the call.

Call End Reason

Call Hangup

The total number of times providers terminated a call to the VRS by hanging up their phone.

Max Txn

The total number of times a call to the VRS was terminated because the caller exceeded the maximum number of transactions allowed per call. The VRS can be configured to allow the user a preset maximum number of inquires per call session. This limit is initially set to four transactions.

Hst Err

The total number of times a call to the VRS was terminated because there was a host error.

Max Err

The total number of calls terminated due to the maximum number of errors input by the user.

Misc

Total number of calls terminated due to reasons other than caller hangup, maximum transactions, host error, or maximum errors.

Transaction Counts:

Recip Elig

Indicates the total number of positive responses given by the VRS to all eligibility requests for the time period.

Benefit Limit

Indicates the total number of benefit limit information requests made on the VRS for the time period.

Remit Advice

Indicates the total number of remittance advice information requests made on the VRS for the time period.

Prior Auth

Indicates the total number of prior authorization information requests made on the VRS for the time period.

```
Report:  AVR-0001-D                            IndianaAIM                                       Run Date:  MM/DD/CCYY
Process:                           Daily Call Statistics Hourly Summary                          Run Time:  HH:MM:SS
Location:                                    For MM/DD/CCYY                                       Page:      99,999

                                            AVERAGE      PER      CALL                    CALL    END   REASON                      TRANSACTION COUNTS
 TIME PERIOD     NUM      NUM       CALL       HOST      NUM     NUM     TIMEOUTS     CALL    MAX TXN  HST ERR   MAX     MISC      RECIP   BENEFIT   REMIT    PRIOR
                CALLS     TXNS    DURATION   RSP TIME    TXNS    ERRS    HOST    USER  HANGUP                       ERR               ELIG    LIMIT    ADVICE    AUTH

HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
HH:00 - HH:59   99999    99999    HH:MM:SS   HH:MM:SS    9999    9999    9999    9999   99999    99999    99999    99999    99999     99999    99999    99999    99999
```

AVR-0001-M Monthly Call Statistics Hourly Summary

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0001-M		Monthly Call Statistics Hourly Summary

Description of Information

The Monthly Call Statistics Hourly Summary (AVR-0001-M) report is sorted by hour and lists the total number of Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions for the time period. The report includes total counts for caller hang-ups, provider-reached maximum number of transactions, host down, or provider-reached maximum number of errors for the time period.

Purpose

EDS employees use the Monthly Call Statistics Hourly Summary Report (AVR-0001-M) to identify peak hours of operation, average duration and transactions per call, types of calls, and call end reasons. It also provides a monthly historical perspective.

Sort Sequence

- *Primary -* Time period

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Monthly

Detailed Field Definitions

Time Period — Indicates the hour of the day that the data represents.

Calls — Indicates the total number of calls made to the Voice Response System (VRS) during the time period.

Num Txns — Indicates the total number of transactions performed during the calls made to the VRS during the time period.

Average Per Call:

Call Duration — The average length of time for phone calls during the time period. The average call duration time is calculated by dividing the total duration of all calls for the time period by the total number of calls for the time period.

$$\text{Call Duration} = \frac{\text{Total duration of all calls}}{\text{num calls}}$$

Hst Rsp Time — The average time the VRS takes to respond to a request or inquiry. This time is calculated by dividing the total time the host takes to respond to all inquires (transactions) for the time period by the total number of calls for the time period

Host Rsp Time	=Total length of host response time / NUM CALLS
Num Txns	The average number of transactions made for the time period. The average number of transactions is calculated by dividing the total number of transactions made for the time period by the total number of calls for the time period. Num Txns = $\frac{\text{Total number of transactions}}{\text{num calls}}$
Num Errs	The average number of errors encountered by the VRS for the time period.
Host Timeouts	The host computer is allowed three time-outs (ten seconds each) to respond to a transaction. If the host does not respond after the third time-out, or if an error occurs during the processing of the transaction, the system terminates the call.
User Timeouts	The user is allowed two user time-outs (ten seconds each) to enter the requested data. On the first time-out, the system prompts the user for the required data. On the second time-out, the system terminates the call.
Call End Reason:	
Call Hangup	The total number of times providers terminated a call to the VRS by hanging up their phone.
Max Txn	The total number of times a call to the VRS was terminated because the caller exceeded the maximum number of transactions allowed per call. The VRS can be configured to allow the user a preset maximum number of inquires per call session. This limit is initially set to four transactions.
Hst Err	The total number of times a call to the VRS was terminated because there was a host error.
Max Err	The total number of calls terminated due to the maximum number of errors input by the user.
Misc	The total number of calls terminated due to reasons other than caller hangup, maximum transactions, host error, or maximum errors.
Transaction Counts:	
Recip Elig	Indicates the total number of positive responses given by the VRS to all eligibility requests for the time period.
Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the time period.
Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the time period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the time period.

```
          Report:  AVR-0001-M                                  IndianaAIM                                      Run Date:  MM/DD/CCYY
          Process:                                 Monthly Call Statistics Hourly Summary                       Run Time:  HH:MM:SS
          Location:                                For Period MM/DD/CCYY - MM/DD/CCYY                           Page:        99,999

                                               AVERAGE        PER         CALL                 CALL    END    REASON                TRANSACTION COUNTS
 TIME PERIOD     NUM     NUM      CALL       HOST      NUM    NUM      TIMEOUTS      CALL      MAX     HST     MAX                RECIP    BENEFIT   REMIT   PRIOR
                CALLS   TXNS    DURATION   RSP TIME   TXNS    ERRS   HOST    USER    HANGUP    TXN     ERR     ERR     MISC        ELIG    LIMIT    ADVICE    AUTH

HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
HH:00 - HH:59   99999   99999   HH:MM:SS   HH:MM:SS   9999    9999   9999    9999    99999    99999   99999   99999   99999       99999    99999     99999   99999
```

AVR-0001-W Weekly Call Statistics Hourly Summary

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0001-W		Weekly Call Statistics Hourly Summary

Description of Information

The Weekly Call Statistics Hourly Summary (AVR-0001-W) report is sorted by hour and lists the total number of Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions for the time period. The report includes total counts for caller hang-ups, provider-reached maximum number of transactions, host down, or provider-reached maximum number of errors for the time period.

Purpose

EDS employees use the Weekly Call Statistics Hourly Summary Report (AVR-0001-W) to identify peak hours of operation, average duration and transactions per call, types of calls, and call end reasons.

Sort Sequence

- *Primary* - Time period

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Weekly

Detailed Field Definitions

Time Period	Indicates the hour of the day that the data represents.
Num Calls	Indicates the total number of calls made to the Voice Response System (VRS) during the time period.
Num Txns	Indicates the total number of transactions performed during the calls made to the VRS during the time period.

Average Per Call:

Call Duration The average length of time for phone calls during the time period. The average call duration time is calculated by dividing the total duration of all calls for the time period by the total number of calls for the time period.

$$\text{Call Duration} = \frac{\text{Total duration of all calls}}{\text{num calls}}$$

Hst Rsp Time The average time the VRS takes to respond to a request or inquiry. This time is calculated by dividing the total time the host takes to respond to all inquires (transactions) for the time period by the total number of calls for the time period.

$$\text{Host Rsp Time} = \frac{\text{Total length of host response time}}{\text{num calls}}$$

Num Txns The average number of transactions made for the time period. The average number of transactions is calculated by dividing the total number of transactions made for the time period by the total number of calls for the time period.

$$\text{Num Txns} = \frac{\text{Total number of transactions}}{\text{num calls}}$$

Num Errs The average number of errors encountered by the VRS for the time period.

Host Timeouts The host computer is allowed three time-outs (ten seconds each) to respond to a transaction. If the host does not respond after the third time-out, or if an error occurs during the processing of the transaction, the system terminates the call.

User Timeouts The user is allowed two user time-outs (ten seconds each) to enter the requested data. On the first time-out, the system prompts the user for the required data. On the second time-out, the system terminates the call.

Call End Reason

Call Hang-up The total number of times providers terminated a call to the VRS by hanging up their phone.

Max Txn The total number of times a call to the VRS was terminated because the caller exceeded the maximum number of transactions allowed per call. The VRS can be configured to allow the user a preset maximum number of inquires per call session. This limit is initially set to four transactions

Hst Err The total number of times a call to the VRS was terminated because there was a host error.

Max Err The total number of calls terminated due to the maximum number of errors input by the user.

Misc The total number of calls terminated due to reasons other than caller hang-up, maximum transactions, host error, or maximum errors.

Transaction Counts:

Recip elig Indicates the total number of positive responses given by the VRS to all

	eligibility requests for the time period.
Benefit limit	Indicates the total number of benefit limit information requests made on the VRS for the time period.
Remit advice	Indicates the total number of remittance advice information requests made on the VRS for the time period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the time period.

```
         Report:  AVR-0001-W                                                 IndianaAIM                                             Run Date:  MM/DD/CCYY
         Process:                                    Weekly Call Statistics Hourly Summary                                    Run Time:  HH:MM:SS
         Location:                                     For Period MM/DD/CCYY - MM/DD/CCYY                                       Page:      99,999

                                                AVERAGE        PER        CALL                   CALL    END    REASON                TRANSACTION COUNTS
 TIME PERIOD     NUM     NUM       CALL       HOST     NUM     NUM      TIMEOUTS      CALL     MAX      HST     MAX               RECIP   BENEFIT    REMIT   PRIOR
                CALLS    TXNS    DURATION   RSP TIME   TXNS   ERRS    HOST    USER   HANGUP    TXN      ERR     ERR    MISC        ELIG    LIMIT    ADVICE   AUTH

HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
HH:00 - HH:59   99999   99999    HH:MM:SS   HH:MM:SS   9999   9999    9999    9999    99999   99999    99999   99999   99999      99999    99999     99999   99999
```

AVR-0002-D Daily Summary by Provider Number

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0002-D		Daily Summary by Provider Number

Description of Information

The Daily Summary by Provider Number (AVR-0002-D) report includes total calls and transactions as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider number. The report also splits out the call end reasons for all calls received from a particular provider. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Daily Summary by Provider Number to track voice response eligibility verification calls and transactions by provider number. A provider with a high volume of calls can be targeted and converted to an OMNI device or NECS software for better service.

Sort Sequence

- *Primary -* Provider number

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Daily

Detailed Field Definitions

Provider Num — The system-assigned unique number which identifies a provider.

Total Calls — Indicates the total number of calls made to the VRS by that provider during the reporting period.

Total Txns — Indicates the total number of transactions requested on the VRS by that provider during the reporting period.

Transaction Counts:

Recip Elig — Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.

Benefit Limit — Indicates the total number of benefit limit information requests made on the VRS for the reporting period.

Remit Advice — Indicates the total number of remittance advice information requests made

	on the VRS for the reporting period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason:	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
Report:  AVR-0002-D                                 IndianaAIM                                        Run Date:  MM/DD/CCYY
Process:                                  Daily Summary by Provider Number                            Run Time:  HH:MM:SS
Location:                                         For MM/DD/CCYY                                      Page:      99,999

                                                       TRANSACTION   COUNTS          _                 CALL   END   REASON   COUNTS          _
  PROV       TOTAL     TOTAL      RECIP      BENEFIT      REMIT        PRIOR       CALL          MAX         HST         MAX
 NUMBER      CALLS     TXNS       ELIG       LIMIT        ADVICE       AUTH        HANGUP        TXN         ERR         ERR         MISC

999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
999999999   99,999   999,999    999,999    999,999      999,999      999,999     999,999       999,999     999,999     999,999     999,999
```

AVR-0002-M Monthly Summary by Provider Number

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0002-M		Monthly Summary by Provider Number

Description of Information

The Monthly Summary by Provider Number (AVR-0002-M) report includes total calls and transactions as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider number. The report also splits out the call end reasons for all calls received from a particular provider. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Monthly Summary by Provider Number to track voice response eligibility verification calls and transactions by provider number. A provider with a high volume of calls can be targeted and converted to an OMNI device or NECS software for better service. This report is a consolidation of the weekly summary reports (AVR-0002-W).

Sort Sequence

- *Primary -* Provider number

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Monthly

Detailed Field Definitions

Prov Number	The system-assigned unique number which identifies a provider.
Total Calls	Indicates the total number of calls made to the VRS by that provider during the reporting period.
Total Txns	Indicates the total number of transactions requested on the VRS by that provider during the reporting period.
Transaction Counts	
Recip Elig	Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.
Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the reporting period.
Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.

Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.

Call End Reason:

Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
    Report:  AVR-0002-M                                    IndianaAIM                                                 Run Date:  MM/DD/CCYY
    Process:                                   Monthly Summary by Provider Number                                     Run Time:  HH:MM:SS
    Location:                                  For Period MM/DD/CCYY - MM/DD/CCYY                                     Page:      99,999

                                                     ________________TRANSACTION   COUNTS_________   _____________CALL   END   REASON   COUNTS__________
   PROV       TOTAL     TOTAL       RECIP        BENEFIT      REMIT        PRIOR       CALL          MAX           HST           MAX
  NUMBER      CALLS     TXNS        ELIG         LIMIT        ADVICE       AUTH        HANGUP        TXN           ERR           ERR           MISC

 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
 999999999   99,999   999,999     999,999      999,999      999,999      999,999      999,999      999,999       999,999       999,999       999,999
```

AVR-0002-W Weekly Summary by Provider Number

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0002-W		Weekly Summary by Provider Number

Description of Information

The Weekly Summary by Provider Number (AVR-0002-W) report includes total calls and transactions as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider number. The report also splits out the call end reasons for all calls received from a particular provider. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Weekly Summary by Provider Number to track voice response eligibility verification calls and transactions by provider number. A provider with a high volume of calls can be targeted and converted to an OMNI device or NECS software for better service. This report is a weekly consolidation of the daily reports (AVR-0002-D).

Sort Sequence

- *Primary -* Provider number

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Weekly

Detailed Field Definitions

Prov Number	The system-assigned unique number which identifies a provider.
Total Calls	Indicates the total number of calls made to the VRS by that provider during the reporting period.
Total Txns	Indicates the total number of transactions requested on the VRS by that provider during the reporting period.
Transaction Counts:	
Recip Elig	Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.
Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the reporting period.
Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.

Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason:	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
    Report:  AVR-0002-W                                                 IndianaAIM                                                Run Date:  MM/DD/CCYY
    Process:                                                 Weekly Summary by Provider Number                                      Run Time:  HH:MM:SS
    Location:                                               For Period MM/DD/CCYY - MM/DD/CCYY                                        Page:      99,999

                                                  TRANSACTION   COUNTS               _                              CALL   END   REASON    COUNTS    _
  PROV        TOTAL      TOTAL        RECIP       BENEFIT       REMIT        PRIOR       CALL         MAX          HST           MAX
 NUMBER       CALLS      TXNS         ELIG         LIMIT       ADVICE        AUTH        HANGUP       TXN          ERR           ERR           MISC

999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
999999999    99,999     999,999      999,999      999,999      999,999      999,999     999,999     999,999      999,999       999,999        999,999
```

AVR-0003-D Daily Summary by Provider Type

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0003-D		Daily Summary by Provider Type

Description of Information

The Daily Summary by Provider Type (AVR-0003-D) report includes total calls and transactions as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider type. The report also splits out the call end reasons for all calls received from a particular provider type. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Daily Summary by Provider Type to track voice response eligibility verification calls and transactions by provider type. This report helps identify target audiences for education and possible conversion to another EVS alternative.

Sort Sequence

- *Primary -* Provider type

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Daily

Detailed Field Definitions

Prov Type	This indicates the type of service the provider is currently on file as able to provide. Valid values are found in the Tables Manual. This is the primary sort key for the report
Description	The description for the numeric provider type code.
Total Calls	Indicates the total number of calls made to the VRS by that provider during the reporting period.
Total Txns	Indicates the total number of transactions requested on the VRS by that provider during the reporting period.
Transaction Counts	
Recip Elig	Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.
Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the reporting period.

Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
  Report:  AVR-0003-D                                                 IndianaAIM                                               Run Date:  MM/DD/CCYY
  Process:                                                  Daily Summary by Provider Type                                       Run Time:  HH:MM:SS
  Location:                                                         For MM/DD/CCYY                                                 Page:      99,999

                                                                 TRANSACTION COUNTS                             _           CALL   END   REASON          _
PROV     PROV TYPE      TOTAL       TOTAL        RECIP      BENEFIT       REMIT        PRIOR         CALL          MAX          HST          MAX
TYPE    DESCRIPTION     CALLS       TXNS         ELIG         LIMIT       ADVICE      AUTH         HANGUP          TXN          ERR          ERR          MISC

 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX   999,999     999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999      999,999      999,999
```

AVR-0003-M Monthly Summary by Provider Type

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0003-M		Monthly Summary by Provider Type

Description of Information

The Monthly Summary by Provider Type (AVR-0003-M) report includes total calls and transactions, as well as totals for Eligibility, Benefit Limit, Remittance Advice, Prior Authorization, and Claim Status transactions by provider type. The report also splits out the call end reasons for all calls received from a particular provider type. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Monthly Summary by Provider Type to track voice response eligibility verification calls and transactions by provider type. This report helps identify target audiences for education and possible conversion to another EVS alternative. This monthly report is a consolidation of the weekly reports (AVR-0003-W).

Sort Sequence

- *Primary -* Provider type

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Monthly

Detailed Field Definitions

Prov Type	This indicates the type of service the provider is currently on file as able to provide. Valid values are found in the Tables Manual. This is the primary sort key for the report.
Description	The description for the numeric provider type code.
Total Calls	Indicates the total number of calls made to the VRS by that provider during the reporting period.
Total Txns	Indicates the total number of transactions requested on the VRS by that provider during the reporting period.
Transaction Counts	
Recip Elig	Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.
Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the reporting period.

Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
        Report:  AVR-0003-M                                                 IndianaAIM                                               Run Date:  MM/DD/CCYY
        Process:                                                 Monthly Summary by Provider Type                                      Run Time:  HH:MM:SS
        Location:                                               For Period MM/DD/CCYY - MM/DD/CCYY                                       Page:      99,999

                                                                TRANSACTION COUNTS                                          CALL   END   REASON          _
                                               =
PROV     PROV TYPE      TOTAL        TOTAL        RECIP       BENEFIT      REMIT        PRIOR        CALL          MAX          HST          MAX
TYPE    DESCRIPTION     CALLS         TXNS        ELIG         LIMIT       ADVICE       AUTH        HANGUP         TXN          ERR          ERR         MISC

 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999     999,999      999,999      999,999      999,999      999,999     999,999
```

AVR-0003-W Weekly Summary by Provider Type

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0003-W		Weekly Summary by Provider Type

Description of Information

The Weekly Summary by Provider Type (AVR-0003-W) report includes total calls and transactions as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider type. The report also splits out the call end reasons for all calls received from a particular provider type. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Weekly Summary by Provider Type to track voice response eligibility verification calls and transactions by provider type. This report helps identify target audiences for education and possible conversion to another EVS alternative. This weekly report is a consolidation of the daily reports (AVR-0003-D).

Sort Sequence

- *Primary -* Provider type

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Weekly

Detailed Field Definitions

Prov Type
This indicates the type of service the provider is currently on file as able to provide. Valid values are found in the Tables Manual. This is the primary sort key for the report

Description
The description for the numeric provider type code.

Total Calls
Indicates the total number of calls made to the VRS by that provider during the reporting period.

Total Txns
Indicates the total number of transactions requested on the VRS by that provider during the reporting period.

Transaction Counts

Recip Elig
Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.

Benefit Limit
Indicates the total number of benefit limit information requests made on the VRS for the reporting period.

Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason:	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
         Report:  AVR-0003-W                                                  IndianaAIM                                               Run Date:  MM/DD/CCYY
         Process:                                                  Weekly Summary by Provider Type                                       Run Time:  HH:MM:SS
         Location:                                               For Period MM/DD/CCYY - MM/DD/CCYY                                        Page:      99,999

                                                                     TRANSACTION COUNTS         _                             CALL   END   REASON           _
PROV     PROV TYPE      TOTAL        TOTAL        RECIP       BENEFIT       REMIT        PRIOR        CALL          MAX          HST          MAX
TYPE    DESCRIPTION     CALLS         TXNS         ELIG        LIMIT        ADVICE       AUTH        HANGUP         TXN          ERR          ERR          MISC

 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
 99    XXXXXXXXXXXX    999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999      999,999
```

AVR-0004-D Daily Summary by Provider County

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0004-D		Daily Summary by Provider County

Description of Information

The Daily Summary by Provider County (AVR-0004-D) report includes total calls and transactions, as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider county. The report also splits out the call end reasons for all calls received from a particular provider county. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Daily Summary by Provider County to track voice response eligibility verification calls and transactions by provider county. This information helps identify counties using AVR so they can be educated about other, more efficient alternatives.

Sort Sequence

- *Primary -* Provider county

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Daily

Detailed Field Definitions

Prov County — This indicates the County of service in which the provider is currently on file as able to provide. Valid values are found in the Tables Manual. This is the primary sort key for the report

Total Calls — Indicates the total number of calls made to the VRS by that provider during the reporting period.

Total Txns — Indicates the total number of transactions requested on the VRS by that provider during the reporting period.

Transaction Counts

Recip Elig — Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.

Benefit Limit — Indicates the total number of benefit limit information requests made on the VRS for the reporting period.

Remit Advice — Indicates the total number of remittance advice information requests made on the VRS for the reporting period.

Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason:	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
         Report:  AVR-0004-D                                                 IndianaAIM                                              Run Date:  MM/DD/CCYY
         Process:                                                 Daily Summary by Provider County                                     Run Time:  HH:MM:SS
         Location:                                                     For Period MM/DD/CCYY                                             Page:       99,999

                                              ________________TRANSACTION   COUNTS________________       ___________________CALL   END   REASON     ___________
 PROV        TOTAL       TOTAL        RECIP         BENEFIT        REMIT          PRIOR          CALL           MAX            HST            MAX
COUNTY       CALLS       TXNS          ELIG          LIMIT         ADVICE          AUTH         HANGUP          TXN            ERR            ERR           MISC

  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
  99        999,999     999,999      999,999        999,999       999,999        999,999        999,999       999,999        999,999        999,999       999,999
```

AVR-0004-M Monthly Summary by Provider County

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0004-M		Monthly Summary by Provider County

Description of Information

The Monthly Summary by Provider County (AVR-0004-M) report includes total calls and transactions, as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider county. The report also splits out the call end reasons for all calls received from a particular provider county. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Monthly Summary by Provider County to track voice response eligibility verification calls and transactions by provider county. This information helps identify counties using AVR so that they can be educated about other more efficient alternatives. This report is a consolidation of the weekly reports (AVR-0004-W).

Sort Sequence

- *Primary -* Provider county

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Monthly

Detailed Field Definitions

Prov County	This indicates the County of service in which the provider is currently on file as able to provide. Valid values are found in the Tables Manual. This is the primary sort key for the report
Total Calls	Indicates the total number of calls made to the VRS by that provider during the reporting period.
Total Txns	Indicates the total number of transactions requested on the VRS by that provider during the reporting period.
Transaction Counts:	
Recip Elig	Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.
Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the reporting period.

Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason:	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
        Report:  AVR-0004-M                                    IndianaAIM                                     Run Date:  MM/DD/CCYY
        Process:                                  Monthly Summary by Provider County                           Run Time:  HH:MM:SS
        Location:                                 For Period MM/DD/CCYY - MM/DD/CCYY                           Page:      99,999

                                                                TRANSACTION   COUNTS_______________                  CALL   END   REASON     __________
  PROV      TOTAL        TOTAL        RECIP        BENEFIT       REMIT          PRIOR          CALL           MAX            HST            MAX
 COUNTY     CALLS        TXNS         ELIG          LIMIT        ADVICE          AUTH         HANGUP          TXN            ERR            ERR           MISC

   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
   99      999,999      999,999      999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999       999,999
```

AVR-0004-W Weekly Summary by Provider County

Functional Area	Report Number	Job Name	Report Title
Automated Voice Response	AVR-0004-W		Weekly Summary by Provider County

Description of Information

The Weekly Summary by Provider County (AVR-0004-W) report includes total calls and transactions, as well as totals for Eligibility, Benefit Limit, Provider Remittance Advice, Prior Authorization, and Claim Status transactions by provider county. The report also splits out the call end reasons for all calls received from a particular provider county. This information is calculated by the Voice Response System (VRS) based on caller requests and host responses.

Purpose

EDS uses the Automated Voice Response Weekly Summary by Provider County to track voice response eligibility verification calls and transactions by provider county. This information helps identify counties using AVR so they can educated about other, more effective alternatives. This weekly report is a consolidation of the daily reports (AVR-0004-D).

Sort Sequence

- *Primary -* Provider county

Distribution

To	Media	Copies	Frequency
Requestor	Paper	1	Weekly

Detailed Field Definitions

Prov County — This indicates the County of service in which the provider is currently on file as able to provide. Valid values are found in the Tables Manual. This is the primary sort key for the report

Total Calls — Indicates the total number of calls made to the VRS by that provider during the reporting period.

Total Txns — Indicates the total number of transactions requested on the VRS by that provider during the reporting period.

Transaction Counts:

Recip Elig — Indicates the total number of positive responses given by the VRS to all eligibility requests for the reporting period.

Benefit Limit	Indicates the total number of benefit limit information requests made on the VRS for the reporting period.
Remit Advice	Indicates the total number of remittance advice information requests made on the VRS for the reporting period.
Prior Auth	Indicates the total number of prior authorization information requests made on the VRS for the reporting period.
Claim Status	Indicates the total number of claim status information requests made on the VRS for the reporting period.
Call End Reason:	
Call Hang-up	The total number of times during the reporting period that a call to the VRS terminated due to the caller hanging up.
Max Txn	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of transactions.
Hst Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller receiving a host error on their inquiry transaction.
Max Err	The total number of times during the reporting period that a call to the VRS terminated due to the caller entering the maximum number of input errors.
Misc	The total number of times during the reporting period that a call to the VRS terminated for a reason other than Caller Hang-up, Max Txns, Host Error, or Max Error.

```
       Report:  AVR-0004-W                                                 IndianaAIM                                                   Run Date:  MM/DD/CCYY
       Process:                                                Weekly Summary by Provider County                                          Run Time:  HH:MM:SS
       Location:                                              For Period MM/DD/CCYY - MM/DD/CCYY                                            Page:      99,999

                                               ________________TRANSACTION   COUNTS_______________       _________________CALL   END   REASON      __________
 PROV        TOTAL        TOTAL          RECIP         BENEFIT        REMIT         PRIOR         CALL         MAX           HST           MAX
COUNTY       CALLS         TXNS          ELIG           LIMIT         ADVICE         AUTH        HANGUP        TXN           ERR           ERR          MISC

  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
  99        999,999      999,999        999,999       999,999        999,999       999,999      999,999      999,999      999,999        999,999       999,999
```

Section 4: BIA Reports

BIA-1001-M Buy-In Part A Billing (Receiving)

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1001-M		Buy-In Part A Billing (Receiving)

Description of Information

The Buy-In Part A Billing Report is a paper copy of the system-generated monthly tape from CMS. This report informs Indiana of the status of Buy-In Part A Medicaid recipients by using transaction codes to communicate an update, or an acknowledgment of State accretion, deletion or change.

Purpose

The purpose of the Buy-In Part A Billing Report is to display CMS's current full listing of billing records and acknowledgments of State accretion, deletion, and change records.

Sort Sequence

- Primary - HIB number (Social Security claim numbers), in ascending order with left justification

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Recipient's Medicare number on the Buy-In Part A billing tape received from CMS monthly.
Last	Recipient's last name on the Buy-In Part A billing tape.
First	Recipient's first name on the Buy-In Part A billing tape.
Mi	Recipient's middle initial on the Buy-In Part A billing tape.
Sex	Identifies recipient's numeric sex code on the Buy-In Part A billing tape.
Birth/New HIB	This field contains either the recipient's date of birth (mmddyy) or the new HIB on the Buy-In Part A billing tape. Also, this position may contain an alpha/numeric character for the last number in the date of birth if CMS shows a different DOB. This alphabetic character is equal to the new number, for example 1=A, 2=B and so on.
Agency Code	Identifies the three-character alphanumeric on the Buy-In Part A billing tape that CMS has assigned each state. Refer to the *Buy-In Manual* for valid values.

Sub	Identifies a one-character alpha/numeric code on the Buy-In Part A billing tape that conveys additional information in conjunction with designated transaction codes. Refer to the *Buy-In Manual* for valid values.
Agency/Date	The Agency/Date field may contain the Sub Code effective date, mmyy, which is found right next to the sub code on the Billing A Tape. This same field may also have a three character alpha/numeric agency code for another state on the Buy-In Part A billing tape
Billing Dte	A four-character numeric code which identifies the month and year, mmyy, the State is billed for a recipient's premiums, as displayed on the Buy-In Part A billing tape.
Txn	The first two characters of the four-character code describing CMS's most recent response to State accretion, deletion, or changed records as shown on the Buy-In Part A billing tape. The last two characters are the modifier code, which describes the State or EDS action for that recipient (accretion, deletion, or charge). Refer to the Buy-In Manual for the transaction codes. The second two characters on the transaction codes may be zeros or blank. Refer to the *Buy-In Manual*. as shown on the Buy-In Part A billing tape. The last two characters are the modifier code, which describes the State or EDS action for that recipient (accretion, deletion, or charge). Refer to the Buy-In Manual for the transaction codes. The second two characters on the transaction codes may be zeros or blank. Refer to the *Buy-In Manual*.
Eff Date	The effective date of the transaction during which the recipient was accreted, deleted, or changed Buy-In Part A status as shown on the Buy-In Part A billing tape. This field may be blank
RID	Recipient's 12-character numeric identification number on the Buy-In Part A billing tape. This field may be all zeros or an invalid number sent by CMS.
Premium Amount	A six character numeric code describing the premium amount billed by CMS to the State for a recipient's Buy-In Part A premiums.
Normal Billing	Includes all 41bb transaction codes from the billing tape. The 41bb (41__) is an ongoing Buy In Part A recipient. CMS has already bought this recipient in and continues to bill IFSSA a monthly premium.
Total Accretions	The enrollment of a recipient in the Buy In Part A program. The total number of accretions on the Buy-In Part A billing tape. The accretion codes are 11XX and 43XX. Refer to the *Buy-In manual* for the transaction codes.
Total Deletions	The removal of a recipient from the Buy In Part A program. Total number of deletions on the Buy-In Part A billing tape. The deletion codes are 14bb, 15bb, 16bb, 17XX, 42bb (42__), and 42XX. Refer to the *Buy-In manual* for the transaction codes.
Total Miscellaneous	Total number of all other transaction codes that are not accretions or deletions on the Buy-In Part A billing tape. Refer to the *Buy-In manual* for the transaction codes.
Total Number Of Records Received From HCFA	Summary of all Normal Billing accretions, deletions, and miscellaneous transactions sent by CMS on the Buy-In Part A billing tape and received by IFSSA

Debits	The changes to the State for recipient part A Premiums. The transaction codes are used by CMS to inform the State that recipients have been bought in transaction code (41bb) or are in the process of being bought in transaction code (11XX), having their premium paid, or are having a debit adjustment with transaction code (43XX) for these recipients. Refer to the Buy-In manual for the transaction codes.
Items	The total number of records for each debit transaction code appearing on the billing tape.
Money	The total dollar amount for each debit transaction code appearing on the billing tape.
Total	Total number of records for all credits transaction code appearing on the billing tape.
Credits	Credits to the State's Part A Buy In account for previous premiums paid in error. The transaction codes used by CMS to inform the State of overpayments for a recipient's Part A premium are as follows: 14bb, 15bb, 16bb, 17XX, 42bb, and 42XX. Refer to the *Buy-In manual* for the transaction codes.
Items	The total number of records for each credit transaction code appearing on the billing tape.
Money	The total number of records for each credit transaction code appearing on the billing tape.
Total	Total number of records for all credits transaction code appearing on the Billing tape.
Miscellaneous Codes	These are transaction codes used by CMS to inform the State of errors on the previous month Premium S15 tape, and various changes in CMS's or SSA's records, such as the status of a case. The miscellaneous codes are: 20XX, 21XX, 23XX, 24XX, 25XX, 27XX, 29XX, 30XX, 31XX, 49XX. Refer to the *Buy-In manual* for the transaction codes.
Items	The total number of records for miscellaneous transaction codes appearing on the Billing tape.
Total	Total number of records for all credit transaction codes appearing on the Billing tape.
HCFA Premium Dollar Billed	This is an accounting of the total dollar amount billed by CMS.
Debits	This is the total dollar amount CMS is billing IFSSA for Part A premium, and should equal the total debit mention earlier.
Credits	This is the total dollar amount CMS is crediting IFSSA for recipients Part A premium, and should equal total credit mentioned earlier.
Total Billed	This is the total dollar amount CMS is billing IFSSA for Buy In Part A premiums, which is equal to the debits minus the credits.

```
Report:  BIA-1001-M                             IndianaAIM                                      Run Date:  MM/DD/CCYY
Process:                                                                                             Run Time:  HH:MM
Location:                                BUY-IN PART A BILLING (RECEIVING)                      Page:      99,999

                                                                 BIRTH/  AGENCY    SUB AGENCY/  BILLING        EFF                     PREMIUM
              HIB         LAST          FIRST     MI     SEX    NEW HIB   CODE          DATE     DATE    TXN   DATE        RID          AMOUNT

         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99
         999999999999  XXXXXXXXXXXX    XXXXXXX     X      9      mmddyy    999       X   9999      mmyy    9999   mmyy   999999999999   $9,999.99



                                         NORMAL BILLING:                      99,999,999,999
                                         TOTAL ACCRETIONS:                    99,999,999,999
                                         TOTAL DELETIONS:                     99,999,999,999
                                         TOTAL MISCELLANEOUS:                 99,999,999,999

                        TOTAL NUMBER OF RECORDS RECEIVED FROM HCFA:           99,999,999,999
```

```
Report:  BIA-1001-M                          IndianaAIM                          Run Date:  MM/DD/CCYY
Process:                                                                          Run Time:  HH:MM
Location:                                BUY-IN PART A BILLING (RECEIVING)       Page No.:  99,999

                                      BUY-IN STATISTICS SUMMARY


DEBITS                                          CREDITS                                  MISCELLANEOUS

                 ITEMS                MONEY                          ITEMS                MONEY
                ITEMS

CODE 11              99,999,999          $99,999,999          CODE 14       99,999,999          $99,999,999
      CODE 20        999,999
CODE 41              99,999,999          $99,999,999          CODE 15       99,999,999          $99,999,999
      CODE 21        999,999
CODE 43              99,999,999          $99,999,999          CODE 16       99,999,999          $99,999,999
      CODE 23        999,999
                                                            CODE 17       99,999,999          $99,999,999
      CODE 24        999,999
                                                            CODE 42       99,999,999          $99,999,999
      CODE 27        999,999
                                                                                                    CODE 29
      999,999
             CODE 30        999,999
TOTAL     9,999,999,999          $9,999,999,999                    9,999,999,999         $9,999,999,999
             CODE 31        999,999
             CODE 49        999,999

             TOTAL     999,999,999
      HCFA PREMIUM DOLLARS BILLED

      DEBIT                $999,999,999
      CREDIT               $999,999,999

      TOTAL BILLED        $9,999,999,999

                                        * * END OF REPORT * *

                                       * * NO DATA THIS RUN * *
```

BIA-1002-M Buy-In Part A Premium S15 (Sending)

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1002-M		Buy-In Part A Premium S15 (Sending)

Description of Information

The Buy-In Part A premium S15 report is a paper copy of the accretion, deletion, or changes made to Buy-In Part A recipients by the State or EDS in a given month. These updates are sent to CMS on a monthly tape. CMS responds to each entry by sending the Buy-In Part A billing tape.

Purpose

The purpose of the Buy-In Part A premium S15 report is to notify CMS of any recipient accretion, deletion, or changes after the monthly Buy-In Part A billing tape is run.

Sort Sequence

- *Primary -* HIB number (Social Security), ascending, left justification.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Recipient's Medicare number on the Buy-In Part A Premium S15 Tape sent to CMS.
Last	Recipient's Medicare number on the Buy-In Part A Premium S15 Tape sent to CMS.
First	Recipient's first name on the Buy In Part A Premium S15 Tape.
MI	Recipient's middle initial on the Buy-In Part A Premium S15 Tape
Sex	Identifies recipient's numeric sex code on the Buy-In Part A Premium S15 Tape
Birth	Recipient's date of birth (mmddyy) on the Buy-In Part A Premium S15 Tape.
Agency Code	A three-character alphanumeric value on the Buy-In Part A Premium S15 Tape that CMS has assigned to each state. Refer to the *Buy-In manual* for agency codes.

Txn	The two-character numeric code sent to CMS indicating an EDS or IFSSA update, accretion, deletion, change, requiring a response from CMS. This is also called the *modifier* portion of the transaction code. Refer to the *Buy-In manual* for the transaction codes.
Eff Date	The effective date, in mmyy format, needed for the transaction sent on the Buy-In Part A Premium S15 tape.
Rid	Recipient's 12-character identification number on the Buy-In Part A Premium S15 tape.
Total Accretions	Total number of accretions made by EDS or IFSSA and sent to CMS on the Buy-In Part A Premium S15 tape. The accretion codes are 61 and 75.
Total Deletions	Total number of deletions made by EDS or IFSSA and sent to CMS on the Buy-In Part A Premium S15 tape. The deletion codes are 51, 53, and 76.
Total Changes	Total number of changes made by EDS or IFSSA and sent to CMS on the Buy-In Part A Premium S15 tape. The change record code is 99.
Summary Of Records Sent To HCFA	Summary of all accretions, deletions, and changes made by EDS or IFSSA and sent to HCFA on the Buy-In Part A Premium S15 tape.

```
    Report:  BIA-1002-M                                        IndianaAIM                                      Run Date:  MM/DD/CCYY
    Process:                                                                                                        Run Time:  HH:MM
    Location:                                     BUY-IN PART A PREMIUM S15 (SENDING)                              Page:      99,999


                                                                                         AGENCY                EFF           RID
     HIB              LAST                FIRST           MI     SEX       BIRTH          CODE       TXN       DATE

999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999
999999999999      xxxxxxxxxxxx           xxxxxxx          X       9        mmddyy         XXX         99       mmyy     999999999999

                                            TOTAL ACCRETIONS:                             99,999,999,999
                                            TOTAL DELETIONS:                              99,999,999,999
                                            TOTAL CHANGES:                                99,999,999,999

                                            SUMMARY OF RECORDS SENT TO HCFA:              99,999,999,999


                                                                   * * END OF REPORT * *

                                                                  * NO DATA THIS RUN * *
```

BIA-1003-M Buy-In Part A Exception Error By HIB

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1003-M		Buy-In Part A Exception Error By HIB

Description of Information

The Buy-In Part A Exception Error By HIB Report contains records from the Billing tape that need to be reviewed for different reasons.

The following transaction codes always appear on the Buy-In Part A Exception Error by HIB report: 1128, 1728, 20XX, 21XX, 24XX, 25XX, 27XX, 29XX, 30XX, and 31XX.

The Buy-In Part A transaction codes definition indicates the additional codes that trigger certain records to appear on the Buy-In Part A Exception Error By HIB Report. See the *Buy-In Part A Transaction Code* document found in *Appendix A*.

Purpose

The purpose of the Buy-In Part A Exception Error By HIB Report is to identify the above listed codes from CMS. EDS reviews, researches, and resolves any problems associated with these codes.

Sort Sequence

- *Primary -* HIB number (Social Security), ascending, left justification.

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Recipient's Medicare number on the Buy-In Part A billing tape received from CMS monthly.
Last	Recipient's last name on the Buy-In Part A billing tape
First	Recipient's first name on the Buy-In Part A billing tape.
MI	Recipient's middle initial on the Buy-In Part A billing tape.
Sex	Identifies recipient's numeric sex code on the Buy-In Part A billing tape.
Birth/New HIB	This field contains either the recipient's date of birth, mmddyy, or the new HIB on the Buy In Part A billing tape. Also, this position may contain an alpha/numeric character for the last number in the date of birth if CMS shows a different DOB. This alphabetic character is equal to the new number, for example: 1=A, 2=B, and so on.

Agency Code	Identifies the three-character alpha/numeric code on the Buy-In Part A billing tape that CMS has assigned each state. Refer to the *Buy-In manual* for valid values.)
Sub	Identifies a one-character alpha/numeric code on the Buy-In Part A billing tape that conveys additional information in conjunction with designated transaction codes. Refer to the *Buy-In manual* for valid values.
Agency/Date	The Agency/Date field may contain the Sub Code effective date, in mmyy format, which is found next to the sub code on the Billing A tape. This same field may also have a three-character alpha/numeric agency code for another state on the Buy-In Part A billing tape.
Billing Dte	A four-character numeric code which identifies the month and year (mmyy) the State is billed for a recipient's premiums, as displayed on the Buy-In Part A billing tape.
Txn	The first two characters of the four character code describing CMS's most recent response to State accretion, deletion, or change records as shown on the Buy In Part A billing tape. The last two characters state the modifier code, which describes the State or EDS action for that recipient (accretion, deletion, or change). Refer to the *Buy-In manual* for the transaction codes. The second two characters on the transaction codes may be zeros or blank. Refer to the *Buy-In manual* for valid values.
Eff Date	The effective date of the transaction on which the recipient was accreted, deleted, or changed in Buy-In Part A as shown on the Buy-In Part A billing tape. This field may be blank
RID	Recipient's 12-character numeric identification number on the Buy-In Part A billing tape. This field may be all zeros or an invalid number sent by CMS.
Premium Amount	Recipient's 12-character numeric identification number on the Buy-In Part A billing tape. This field may be all zeros or an invalid number sent by CMS. billed by CMS to the State for a recipient's Buy-In Part A premiums.
Error Code	A two character numeric code further describing transaction code errors that CMS has sent in response to State accretions, deletions, and changes.

```
Report:  BIA-1003-M                                        IndianaAIM                                     Run Date:  MM/DD/CCYY
Process:                                                                                                       Run Time:  HH:MM
Location:                                     BUY-IN PART A EXCEPTION ERROR BY HIB                            Page:      99,999


                                                        BIRTH/   AGENCY  SUB AGENCY/  BILLING            EFF                    PREMIUM    ERROR
      HIB            LAST          FIRST     MI  SEX   NEW HIB    CODE         DATE     DATE     TXN    DATE         RID         AMOUNT    CODE

  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99
  999999999999   XXXXXXXXXXXX     XXXXXXX    X    9     mmddyy     999    X    9999     mmyy     9999   mmyy    999999999999   $9,999.99    99



                                                               * * END OF REPORT * *

                                                             * * NO DATA THIS RUN * *
```

BIA-1004-M Buy-In Part A Exception Error By Transaction Code

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1004-M		Buy-In Part A Exception Error By Transaction Code

Description of Information

The Buy-In Part A Exception Error By Transaction Code Report contains records from the Billing tape that need to be reviewed for different reasons.

The following transaction codes always appear on the Buy-In Part A Exception Error By Transaction Code Report: 1128, 1728, 20XX, 21XX, 24XX, 25XX, 27XX, 29XX, 30XX, and 31XX.

The Buy-In Part A transaction codes definition indicates the additional codes that trigger certain records to appear on the Buy-In Part A Exception Error By Transaction Code Report. See the *Buy-In Part A Transaction Code* document found in *Appendix A.*

Purpose

The purpose of the Buy-In Part A Exception Error By Transaction Code Report is to identify the above listed codes from CMS. EDS reviews, researches and resolves any problems associated with these codes.

Sort Sequence

- *Primary -* transaction codes (the first two digits) and modifier (the last two digits), in numeric order

> *Note: A page break occurs between the different (first two digits) transaction codes.*

- *Secondary -* HIB number within each transaction and modifier code, in ascending order with left justification

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
IFSSA	CRLD	1	Monthly

Detailed Field Definitions

Txn

The first two characters of the four-character code describing CMS's most recent response to State accretion, deletion, or changed records as shown on the Buy-In Part A Billing tape. The last two characters are the modifier code, which describes the action for that recipient (accretion, deletion, or change). Refer to the Buy-In manual for the transaction codes. The second two characters on the transaction codes may be zeros or blank

HIB	Recipient's Medicare number on the Buy-In Part A Billing tape received from
Last	Recipient's last name on the Buy-In Part A Billing tape.
First	Recipient's first name on the Buy-In Part A Billing tape.
MI	Recipient's middle initial on the Buy-In Part A Billing tape.
Sex	Identifies recipient's numeric sex code on the Buy-In Part A Billing tape.
Birth/New HIB	This field contains the recipient's date of birth (mmddyy) or the new HIB on the Buy-In Part A billing tape. This position may also contain an alpha/numeric character for the last number in the date of birth if CMS shows a different DOB. This alphabetic character will be equal to the new number, for example 1=A, 2=B and so on.
Agency Code	Identifies the three-character alphanumeric code on the Buy-In Part A billing tape that CMS has assigned each state. Refer to the Buy-In manual for valid values.
Sub	The three-character code that identifies a one-character alpha/numeric code on the Buy-In Part A billing tape that conveys additional information in conjunction with designated transaction codes.
Agency/Date	The Agency/Date field may contain the Sub Code effective date (mmyy) which is found next to the sub code on the Billing A Tape. This same field may character alpha/numeric agency code for another state on the Buy also have a three In Part A billing tape
Billing Dte	A four-character numeric code which identifies the month and year (mmyy) the State is billed for a recipient's premiums as displayed on the Buy-In Part A billing tape.
Eff Date	The effective date of the transaction on which the recipient was accreted, deleted, or changed in Buy-In Part A as shown on the Buy-In Part A billing tape. This field may be blank.
RID	Recipient's 12-character numeric identification number on the Buy-In Part A Billing tape. This field may be all zeros or an invalid number sent by CMS.
Premium Amount	A six-character numeric code describing the premium amount billed by CMS to the State for a recipient's Buy-In Part A premiums.
Error Code	A two-character numeric code further describing transaction code errors that CMS has sent in response to State accretions, deletions, and changes.

Report: BIA-1004-M Indiana*AIM*
Run Date: MM/DD/CCYY
Process: Run Time:
HH:MM
Location: BUY-IN PART A Exception Error By Transaction Code Page:
99,999

TXN	HIB	LAST	FIRST	MI	SEX	BIRTH/ NEW HIB	AGENCY CODE	SUB	AGENCY DATE	BILL DATE	EFF DATE	RID	PREMIUM AMOUNT	ERROR CODE
9999	999999999999	xxxxxxxxxxxx	xxxxxxx	X	9	mmddyy	999	X	mmyy	mmyy	mmyy	999999999999	$9,999.99	99

* * END OF REPORT * *

* * NO DATA THIS RUN * *

BIA-1005-M Buy-In Part A Recipient's - Without QMB Also or QMB Only

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1005-M		Buy-In Part A Recipient's - Without QMB Also or QMB Only

Description of Information

The Buy-in Part A Recipient's - Without QMB Also or QMB Only Report should have all recipients that are accreted to Buy-In Part A (41__ code on the Billing report) and are not enrolled as QMB recipient on the Aid Category eligibility window or the Dual Aid Category window. This report also reflects the information from the recipient's base and Medicare table after the Buy-In Part A Billing tape has been checked on the Buy-In A Coverage window.

Purpose

The purpose of the Buy-In Part A Recipient's - Without QMB Also or QMB Only Report is to identify the recipients who are in Buy-In Part A, and are not enrolled as a QMB recipient. A recipient who is in Buy-In Part A should have QMB.

Sort Sequence

- *Primary* - County number, ascending, page break after each
- *Secondary* - Caseworker number, ascending within the county
- *Tertiary* - Recipients' last name, alphabetical order

Refer to the current recipient base table for this information.

Distribution

To	Media	Copies	Frequency
Provider	CRLD	1	Monthly
IFSSA	CRLD	1	Monthly

Detailed Field Definitions

County	This report is sorted by ascending county numbers.
Caseworker	Identifies the case worker number assigned to this recipient. This is taken from the recipient base table.
RID	Recipient's 12-character numeric identification number in the recipient base table.
Last	Recipient's last name in the current recipient base table
First	Recipient's first name in the current recipient base table.

MI	Recipient's middle initial in the current recipient base table.
SSN	Recipient's Social Security number in the current recipient base table.
HIB	Current Medicare identification number for that recipient in the recipient Medicare table.
Total	The number of QMB recipients in the Buy-In Part A billing report.

```
Report:  BIA-1005-M                                IndianaAIM                                Run Date:
                    MM/DD/CCYY
Process:                                                                                     Run Time:  HH:MM
Location:                           BUY-IN PART A RECIPIENT'S - Without QMB Also or QMB Only Page:      99,999
                                                   COUNTY:  99

    CASE
   WORKER           RID              LAST                  FIRST          MI        SSN           HIB

   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999
   XXXXXX       999999999999     xxxxxxxxxxxx           xxxxxxx          X      999999999     999999999999


TOTAL:                    999,999,999


                                            * * END OF REPORT * *

                                           * * NO DATA THIS RUN * *
```

BIA-1006-M Buy-In Part A Pending Transactions Awaiting 3 Months Reply

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1006-M		Buy-In Part A Pending Transactions Awaiting 3 Months Reply

Description of Information

The Buy-In Part A Pending Transaction Awaiting 3 Months Reply Report shows the Buy-In Part A Premium S15 entries sent to CMS that have not had a response within three months. The transaction codes included in this report are as follows: 61 (normal accretion), 51 (normal deletion), 53 (death deletion), and 75/76 (simultaneous accrete/delete). Included with this transaction code is the date that the entry was sent to CMS. The transaction code 4999 from CMS does not qualify as a response, because 4999 transactions codes are CMS acceptance or changes for current Buy-In recipients, and do not affect accretions nor deletions of Buy-In.

Purpose

The purpose of the Buy-In Part A Pending Transaction Awaiting 3 Months Reply is to indicate to IFSSA and EDS which recipients CMS has not responded to within the last 3 months.

Sort Sequence

- *Primary* - left justification Social Security claim number (HIB), ascending order with

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Recipient's Medicare number on the Buy-In Part A Premium S15 Tape.
Last	Recipient's last name on the Buy-In Part A Premium S15 Tape.
First	Recipient's first name on the Buy-In Part A Premium S15 Tape.
MI	Recipient's middle initial on the Buy-In Part A Premium S15 Tape.
Sent Txn	The two-character numeric code sent to CMS indicating an EDS or IFSSA update (accretion, deletion, change) requiring a response from CMS. This is also called the Modifier portion of the transaction code. The transaction codes included in this report are as follows: 61 (normal accretion), 51 (normal deletion), 53 (death deletion), and 75/76 (simultaneous accrete/delete).

Sent Date	The date (mmyy) the transaction was sent to CMS on the Buy-In Part A Premium S15 Tape
Eff Date	The effective date the recipient needs the update of the transaction code.
Rcvd TXN	The four-character numeric code received from CMS indicating to EDS or IFSSA the information sent is awaiting a response at a later date. The transaction codes included in the report are as follows: 3061 (CMS adjusting Buy-In effective date to a later date), 3151 (CMS delaying deletion), 3153 (CMS delaying deletion), and 3161 (CMS delaying accretion).
Rcvd Date	The date (mmyy) the transaction was received from CMS on the Buy-in Part A premium S15 Tape.

```
Report:  BIA-1006-M                                IndianaAIM                                  Run Date:
                     MM/DD/CCYY
Process:                                                                                       Run Time:
                     HH:MM
Location:                                BUY-IN PART A PENDING TRANSACTIONS                    Page:
                     99,999
                                              AWAITING 3 MONTHS REPLY


                                                                  SENT         SENT          EFF          RCVD        RCVD
     HIB                 LAST                  FIRST         MI    TXN         DATE          DATE          TXN        DATE

  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy
  999999999999       xxxxxxxxxxxx            xxxxxxx         X     99          mmyy          mmyy          9999        mmyy



                                         * * END OF REPORT * *

                                        * * NO DATA THIS RUN * *
```

BIA-1007-M Buy-In Part A Control Report

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1007-M		Buy-In Part A Control Report

Description of Information

The Buy-In Part A Control Report identifies the Medicare Part A premium amount billed to the State by CMS for the current billing month. The "Billing Month" is the month following the month the Billing tape is received. This report reflects the amount billed and breaks down the amounts by the categories of assistance which qualify for Part A Buy-In (QMB and QDWI). Qualified Medicare Beneficiary (QMB) is further divided into **QMB Also** and **QMB Only**. Recipients who have QDWI qualify to have their Medicare Part A premiums paid by IFSSA. The **Unknown** category includes recipients who do not have a RID number on the Billing tape, or numbers which cannot be matched to a recipient. The category headers are: **QMB Also**, **QMB Only**, **QDWI**, and **Unknown**. The **QMB Also** category is further divided by aid category. This group includes the recipients in aid categories **MAL** or **MALP** and are **Aged**, **Blind**, **Disabled**, or **AFDC**.

The **Premium Totals** include the **Premium Balance** that CMS is billing for each category and a **Combined Total**. The **Combined Total** equals the **CMS Premium Dollars Billed**, which matches the paper copy of the actual Billing tape output CMS sends to the State.

This report further identifies the total number and total amount of premiums billed for the month. Current month and retroactive months totals are reported. Also shown are the totals for the Federal Fiscal Year, State Fiscal Year, and Calendar Year. The last item on this report is the number of records received from CMS and sent to CMS, listed by the different transaction codes.

Purpose

The purpose of the Buy-In Part A Control Report is to reflect the amount CMS is billing IFSSA by category for Medicare Part A premiums in the given billing month, and assist in the calculation of the amount to be paid to CMS for Medicare Part A Buy-In.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	2	Monthly

Detailed Field Definitions

Premiums Billed By Category — This category lists the premium dollar amount billed for recipients under each Medicare Part A Buy In program, and the number of recipients in each

aid category. These are divided into **QMB Also** and **QMB Only/QDWI**. There are a total of seven category headers. Each category shows **Normal Billing**, **Verified Accretions**, **Verified Deletions**, and **Balance** for the given month's billing tape.

The QMB Also

This category reflects Qualified Medicare Beneficiaries. Recipients can be **QMB Also** or **QMB Only**. **QMB Only** recipients are entitled to payments of the Medicare premium(s) and any Medicare co payments or deductibles. **QMB Also** recipients are entitled to the **QMB Only** benefits in addition to Medicaid benefits under one of the following aid categories: **Aged**, **Blind**, **Disabled**, or **AFDC**. The aid categories for all QMB recipients are **MAL**, or **MALP**. **QMB Also** recipients have two aid categories, **MAL**, or **MALP** in addition to their Medicaid eligibility categories **Aged**, **Blind**, **Disabled**, and **AFDC**.

To Identify QMB

To identify recipients for this report the system searches the billing record for an eligibility code of **P** found in position 50. Those without dual eligibility are included in this report under the column **QMB Only**; all others are included in the column for **QMB Also**.

Category Header

These are the aid categories under the Medicare Part A Buy-In QMB program. The category headers are **QMB/AGED**, **QMB/BLIND**, **QMB/DISABLED**, **QMB/AFDC**, and **QMB ALSO TOTAL**.

QMB/Aged

These recipients qualify for Qualified Medicare Beneficiary (QMB) plus Medicaid under the Aged program. The following aid categories comprise AGED for this report: MA A, MA 5, MAAP, and MA5P.

QMB/Blind

These recipients qualify for Qualified Medicare Beneficiary (QMB) plus Medicaid under the **Blind** program. The following aid categories comprise **Blind** for this report: **MA B**, **MA 6**, **MABP**, and **MA6P**

QMB/Disabled

These recipients qualify for Qualified Medicare Beneficiary (QMB) plus Medicaid under the Disabled program. The following aid categories comprise Disabled for this report: **MA D**, **MA R**, **MA 7**, **MADP**, **MARP**, and **MA7P**.

QMB/AFDC

These recipients qualify for Qualified Medicare Beneficiary (QMB) plus Medicaid under the AFDC program. The following aid categories comprise AFDC for this report: **MA C**, **MA F**, **MA H**, **MA O**, **MA Q**, **MA S**, **MA T**, **MA U**, **MA 4**, **MA 8**, **MACP**, **MAFP**, **MAHP**, **MAOP**, **MASP**, **MATP**, **MAUP**, **MA4P**, and **MA8P**.

QMB Also Total

These are the combined totals of the columns as follows: **QMB/AGED**, **QMB/BLIND**, **QMB/DISABLED**, and **QMB/AFDC** Each of the above categories are divided into **NORMAL BILLING**, **VERIFIED ACCRETIONS**, **VERIFIED DELETIONS**, and **BALANCE** depending upon the reported transaction codes.

Normal Billing

This includes all 41bb transaction codes from the Billing Part A tape for each QMB category. The 41bb (41__) is an ongoing Buy In Part A recipient. CMS has already bought in this recipient and continues to bill IFSSA for a monthly premium. Refer to the Buy In manual for the transaction codes.

Verified Accretions	This includes all 11XX and 43XX, and transaction codes. The code 11XX means CMS accepted the accretion attempt for this recipient for the effective date requested. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy-In manual for the transaction codes.
Verified Deletions	This includes all 11XX and 43XX, and transaction codes. The code 11XX means CMS accepted the accretion attempt for this recipient for the effective date requested. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy-In for a recipient for various reasons. These codes indicate IFSSA or CMS is sending a credit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Balance	A balance is given for the total of the **NORMAL BILLING** plus the **VERIFIED ACCRETIONS** minus the **VERIFIED DELETIONS** for each of the following categories: **QMB/AGED**, **QMB/BLIND**, **QMB/DISABLED**, **QMB/AFDC**, and **QMB ALSO TOTAL**.
The QMB only/QDWI	This category reflects recipients who are not eligible for Medicaid but are eligible for Medicare Part A Buy-In premiums paid by IFSSA.
Category Header	These are the aid categories under the Medicare Part A Buy In program. The category headers are **QMB ONLY** and **QDWI**.
QMB Only	These are Qualified Medicare Beneficiaries who are not eligible for Medicaid but are entitled to have their Medicare A Premium(s) and Medicare co-payments or deductibles paid by IFSSA. These recipients are assigned to aid categories **MA L** and **MALP**
QDWI	This includes all recipients who are Qualified Disabled Working Individuals in aid categories **MA G** and **MAGP**. Each of the above categories are divided into **NORMAL BILLING**, **VERIFIED ACCRETIONS**, **VERIFIED DELETIONS**, and **BALANCE** depending on the reported transaction codes.
Normal Billing	This includes all 41bb transaction codes from the Billing Part A Tape for each category. The 41bb (41__) is an ongoing Buy In Part A recipient. CMS has already bought in this recipient and continues to bill IFSSA for monthly premiums. Refer to the Buy In manual for the transaction codes.
Verified Accretions	This includes all 11XX and 43XX transaction codes. The code 11XX indicates CMS has accepted the accretion attempt for this recipient for the effective date requested. The 43XX indicates CMS sent a debit liability. Refer to the Buy In manual for the transaction codes.
Verified Deletions	This includes the following transaction codes: 14bb, 15bb, 16bb, 17XX, 42XX, and 42bb (42__). These codes indicate CMS is discontinuing Buy In for a recipient for various reasons. These codes are a credit to IFSSA or CMS is sending a credit adjustment of premium liability. Refer to the Buy-In manual for the transaction codes.
Balance	A balance is given for the total of the **Normal Billing** plus the **Verified Accretions** minus the **Verified Deletions** for each of the following categories: **QMB ONLY** and **QDWI**. The **PREMIUM TOTALS** category reflects the listing of the Premiums Billed by Category and divided into the following Buy-In Part A programs: **QMB Also**, **QMB**

	Only, **QDWI**, **Unknown**, and **Combined Total**.
Category Header	These are the individual categories for which premiums are paid. They include **QMB Also**, **QMB Only**, **QDWI**, **UNKNOWN**, and **COMBINED TOTAL**
QMB Also	Total premiums for a **Qualified Medicare Beneficiary** who is also eligible for other Medicaid programs. This total is from the **QMB Also Total** column under the **PREMIUMS BILLED BY CATEGORY**.
QMB Only	Total premiums for "Qualified Medicare Beneficiary" who are not eligible for other Medicaid programs. This total is from the "QMB ONLY" column under the "PREMIUMS BILLED BY CATEGORY".
QDWI	Total premiums for Qualified Disabled Working Individuals who are not entitled to benefits.
Unknown	Total premiums for recipients on the billing tape who do not have a RID number or whose number does not have a match in the Eligibility window.
Combined Total	A total of all the above categories; **QMB ALSO**, **QMB** TOTAL**ONLY**, **QDWI**, and **UNKNOWN**, from the billing tape. Each of the above categories are divided into **NORMAL BILLING, VERIFIED ACCRETIONS**, **VERIFIED DELETIONS**, and **BALANCE**, depending upon the reported transaction codes.
Normal Billing	These are the totals from above **NORMAL BILLING** for each of the following programs: **QMB Also**, QMB Only, **QDWI**, **Unknown**, and **Combined Total**.
Verified Accretions	These are the totals from above **VERIFIED ACCRETIONS** for each of the following programs: **QMB Also**, **QMB Only**, **QDWI**, **Unknown**, and **Combined Total**.
Verified Deletions	These are the totals from above **VERIFIED DELETIONS** for each of the following programs: **QMB Also**, **QMB Only**, **QDWI**, **Unknown**, and **Combined Total**.
Balance	This is the balance of the totals of **NORMAL BILLING** plus the **VERIFIED ACCRETIONS**, minus the **VERIFIED DELETIONS** for each program.
Category Header	This is the amount IFSSA may or may not be reimbursed for each recipient that is on Buy In Part A including **FFP**, **NON FFP**, **TOTAL**, **FEDERAL FY**, **STATE FY**, **CALENDAR YEAR**
FFP	The Federal Financial Participation (FFP) is paid by CMS for recipients who are eligible for QMB or Money Grant and IFSSA is paying Medicare premiums.
Non-FFP(N/A)	Non-Federal Financial participation. This is not applicable for this report by State request.
Total	This is the total of **FFP** and **Non FFP** columns
FED FY	The Federal Fiscal Year (FFY) begins October 1, and ends September 30. The Federal Government uses this for annual calculations.

State FY

The State Fiscal Year (SFY) begins July 1, and ends June 30. The State Government uses this for annual calculations.

Calendar Year

This begins January 1, and ends December 31.

The following items are included in the calculation of the number of months and amount of premiums billed on the current months billing tape and the accumulation of the different annual calculations:

- number of current month premiums being billed
- number of retro months premiums being billed
- number of month's credit was received
- number of month's debit was received
- total number of months premiums being billed
- dollar amount of current month premiums being billed
- dollar amount of retro active month premiums being billed
- dollar amount of month's credit was received
- dollar amount of month's debit was received
- total dollar amount of months premiums being billed

Number of Current Month Premiums Being Billed

This is the number of transactions on the Billing tape that have a code 41bb (41__), All of these transaction codes only have the current month effective date. The 11XX has one month's premium (as the current month) and may also include retro months premiums billed. If the effective date of the 11XX is less than the current month, one is the current month and the remaining months are added to the retro months. Therefore, by checking the effective date of the transaction code, the system determines the number of retro months to add. With the exception of codes 1172 and 1175, added months are not for current month premiums unless the 1772 or 1776 effective date shows the current month as the effective date. See retro month below for details. There is an annual cumulative number calculated for Federal Fiscal Year, State Fiscal Year, and Calendar Year.

Number of Retro Months Premiums Being Billed

This is the number of retroactive months for which CMS is billing IFSSA on the current month's Billing tape. To determine this number, the system identifies recipients with transaction codes of 11XX, and 17XX. Then, the system looks at the effective date of each 11XX and 17XX transaction code. If the effective date is equal to the current date, it is added to the current month premium billed. If the effective date is less than the current month, one month is the current month and the rest of the month is counted as retro months premiums billed. The same calculation applies to the two transaction code pairs 1172/1772 and 1175/1776. If the 1772 or 1776 effective date is equal to the current month, one month is the current month and the rest are retro months. *Example*: If the billing tape has an 1161 transaction code with an effective date of 1/94, and the current month is 7/94, the current date is 6/94. One month is put with the current month and the other six months are retro months. If an 1175 has an effective date of 1/94 and the 1776 has a date of 5/94, and the current month is 7/94, all five months are retro months. There is an annual cumulative number calculated for Federal Fiscal Year, State Fiscal Year, and Calendar Year.

Number of Months Credited Was Received

This is the number of months for which a credit was received by the State. This is all the 42bb and 42XX transaction codes. The transaction code with or without an effective date has the following system action. The system takes the current year monthly premium amount (for 1/94 through 12/94 the premium is $245.00 per month, per recipient) and divides by the total amount of premium billed. The number of times the monthly premium can go in to the total premium is the number for that transaction code. If the number does not come out even, round down. There is an annual total calculated for Federal Fiscal Year, State Fiscal Year, and Calendar Year.

Number of Months Debited Was Received

This is the number of months for which a debit was received by the State. This is all the codes. The transaction code with or without an effective date has the following system action. The system takes the current year monthly premium amount (for 1/94 through 12/94, the premium is $245.00 per month, per recipient) and divides by the total amount of premium billed. The number of times the monthly premium can go in to the total premium is the number for that transaction code. If the number does not come out even, it is rounded down. There is an annual total calculated for Federal Fiscal Year, State Fiscal Year, and Calendar Year.

Total Number of Months Premium Being Billed

This is the Number of Current Month Premiums Being Billed plus the Number of Retro Month Premiums Being Billed, plus the Number of Months Credit Was Received, minus the Number of Months Debit Was Received, which equals the Total Number of Months Premiums Billed.

Dollar Amount of Current Month Premiums Being Billed

This is the dollar amount of transactions on the Billing Tape that have a code 41bb (41__); all of these only have the current month effective date. The11XX has one month premiums (as the current month) and may also have retro months premiums billed. If the effective date (*Example*: current billing month of 7/94, current date of 6/94) of the 11XX is less than the current month one is the current month and the remaining months are added to the retro months. Therefore, by checking the effective date of the transaction code, the system determines the amount of retro months to add. With the exception of codes 1172 and11XX has one month premiums (as the current month) and11XX has one month premiums (as the current month) and may also have retro months premiums billed. If the effective date (*Example*: current billing month of 7/94, current date of 6/94) of the 11XX is less than the current month one is the current month and the remaining months are added to the retro months. Therefore, by checking the effective date of the transaction code, the system determines the amount of retro months to add. With the exception of codes 1172 and 1175, the amounts are not for current months premiums unless the 1772 or 1776 effective date shows the current date as the effective date. See retro month below for details. There is not a dollar amount for Federal Fiscal Year, State Fiscal Year, or Calendar Year.

Dollar Amount of Retro Month Premiums Being Billed

This is the dollar amount for retroactive months for which CMS is billing IFSSA on the current month's Billing Tape. To determine this number, the system identifies recipients with transaction codes of 11XX, and 17XX. Then, the system looks at the effective date of each 11XX and 17XX transaction code. If the effective date is equal to the current month, it is added to the current month premium billed. If the effective date is less than the current billing month, one month is the current month and the rest of the months count as retro months premiums billed. The same calculation

	applies to the two transaction code pairs 1172/1772 and 1175/1776. If the 1772 or 1776 effective date is equal to the current month, one month premium is for the current month and the rest of the premium amount is for retro months. (*Example*: If the billing tape has an 1161 transaction code with an effective date of 1/94, and the current billing month is 7/94, one month premium amount is put with the current month and the other six months premiums are retro months. If a 1175 code has an effective of 1/94 and the 1776 has a date of 5/94, and the current date is 7/94, all five months are retro months.) There is not a dollar amount for Federal Fiscal Year, State Fiscal Year, or Calendar Year.
Dollar Amount of Month's Credited Was Received	This is the dollar amount for which a credit was received by the State. This is all the 42bb and 42XX transaction codes. The transaction code with or without an effective date has the whole dollar amount added to this column. There is an annual calculated dollar amount for Federal Fiscal Year, State Fiscal Year, and Calendar Year.
Dollar Amount of Month's Debited Was Received	This is the dollar amount for which a debit was received by the State. This is all the 43XX transaction codes. The transaction code with or without an effective date has the whole dollar amount added to this column. There is an annual calculated dollar amount for Federal Fiscal Year, State Fiscal Year, and Calendar Year
Total Dollar Amt of Month Premiums Being Billed	This is the total from Dollar Amount of Current Month Premiums Being Billed columns plus the Dollar Amount of Retro Month Premium's Being Billed, plus the Dollar Amount Of Month's Credited Was Received, minus the Dollar Amount of Months Debit Was Received equals the Total Dollar Amount of Months Premiums Billed.
Records Received From HCFA	Is an itemization on the Buy In Part A billing tape records by accretions transaction codes (11XX, 41bb, and 43XX), deletions transaction codes (14bb, 15bb, 16bb, 17XX, 42XX, and 42bb), informational transaction codes (20XX, 21XX, 23bb, 23XX, 24XX, 25XX, 27XX, 29XX, 30XX, 31XX, and 49XX) and the total of all transaction codes.
Accretions	This is the number of 11XX, 41bb, and 43XX transaction codes received on the Medicare Part A Buy In Billing tape. Refer to the Buy In Manual for the transaction codes.
Deletions	This is the number of 14bb, 15bb, 16bb, 17XX, 42XX, and 42bb transaction codes received on the Medicare Part A Buy In Billing tape. Refer to the Buy In manual for the transaction codes.
Informational	This is the number of transaction codes used by CMS to inform the State of various informational changes or monitoring codes. The informational codes are as follows: 20XX, 21XX, 23bb, 23XX, 24XX, 25XX, 27XX, 29XX, 30XX, 31XX, and 49XX. Refer to the Buy-In manual for transaction codes.
Total	This is the total of all the Accretions, Deletions, and Informational lines from the above Medicare In Billing tape.
Records Sent	To CMS is an itemization of records on the Premium S15 tape going to CMS from EDS/FSSA.

Accretions	This is the number of 61 and 75 transaction codes on the Premium S15 Tape going to CMS from EDS/FSSA.
Deletions	This is the number of 51, 53, and 76 transaction codes on the Premium S15 Tape going to CMS from EDS/FSSA.
Informational	This is the number of 99 transaction codes on the Premium S15 Tape going to CMS from EDS/FSSA.
Total	This is the total of all records on the Premium S15 Tape going to CMS from EDS/FSSA.

Report: BIA-1007-M Indiana*AIM* Run Date:
MM/DD/CCYY
Process: Run Time:
HH:MM
Location: BUY-IN PART A CONTROL REPORT Page:
99,999

PREMIUMS BILLED BY CATEGORY

QMB ALSO

CATEGORY HEADER	QMB/AGED	+ QMB/BLIND	+ QMB/DISABLED	+ QMB/AFDC	= QMB ALSO TOTAL
NORMAL BILLING	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED DELETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
BALANCE	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999

QMB ONLY/QDWI

CATEGORY HEADER	QMB ONLY	QDWI
NORMAL BILLING	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999
VERIFIED DELETIONS	99,999,999	99,999,999
BALANCE	99,999,999	99,999,999

PREMIUM TOTALS

CATEGORY HEADER	QMB ALSO	+ QMB ONLY	+ QDWI	+ UNKNOWN	= COMBINED TOTAL
NORMAL BILLING	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED DELETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
BALANCE	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999

Report: BIA-1007-M Indiana*AIM* Run Date:
MM/DD/CCYY
Process: Run Time: HH:MM
Location: BUY-IN PART A CONTROL REPORT Page: 99,999

CATEGORY HEADER	FFP	NON FFP	TOTAL	FED FY (Year to date)	STATE FY (Year to date)	CALENDAR YEAR (Year to date)
NUMBER OF CURRENT MONTH'S PREMS BEING BILLED	99,999	N/A	999,999	99,999	99,999	99,999
NUMBER OF RETRO MONTH'S PREMS BEING BILLED	99,999	N/A	999,999	99,999	99,999	99,999
NUMBER OF MONTH'S CREDITED WAS RECEIVED	99,999	N/A	99,999	99,999	99,999	99,999
NUMBER OF MONTH'S DEBITED WAS RECEIVED	99,999	N/A	99,999	99,999	99,999	99,999
TOTAL NUMBER OF MONTH'S PREMIUMS BEING BILLED	9,999,999	N/A	9,999,999	9,999,999	9,999,999	9,999,999
DOLLAR AMOUNT OF CURRENT MONTH'S PREMS BEING BILLED	$99,999,999.99	N/A	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99
DOLLAR AMOUNT OF RETRO MONTH'S PREMS BEING BILLED	$999,999,999.99	N/A	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99
DOLLOR AMOUNT OF MONTH'S CREDITED WAS RECEIVED	999,999,999.99	N/A	999,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
DOLLOR AMOUNT OF MONTH'S DEBITED WAS RECEIVED	999,999,999,.99	N/A	999,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
TOTAL DOLLOR AMOUNT OF PREMIUMS BEING BILLED	999,999,999.99	N/A	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99

RECORDS RECEIVED FROM HCFA

ACCRETIONS:	99,999,999
DELETIONS:	99,999,999
INFORMATIONAL:	99,999,999
TOTAL:	9,999,999,999

RECORD SENT TO HCFA

ACCRETIONS:	99,999,999
DELETIONS:	99,999,999
INFORMATIONAL:	99,999,999
TOTAL:	9,999,999,999

** END OF REPORT **

** NO DATA THIS RUN **

BIA-1008-M Buy-In Part A Qualified Working Individuals

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIA-1008-M		Buy-In Part A Qualified Working Individuals

Description of Information

The Buy-In Part A Qualified Disabled Working Individuals (QDWI) report is a listing from the Buy-In Part A Billing tape of those individuals accreted, deleted, or changed on the QDWI program in Buy-In Part A. These individuals only qualify for premiums paid by the State of Indiana.

Purpose

The purpose of the Buy-In Part A Qualified Working Individuals report is to identify those recipients who are in the QDWI program in Buy-In Part A. The report only displays recipients added, deleted or changed in that month. If there are no adds, deletes, or changes, the report will display **No Data This Run**.

Sort Sequence

- *Primary* - Social Security claim number (HIB), ascending with left justification.

Distribution

To	Media	Copies	Frequency
EDS	CRLD	0	Monthly
IFSSA	CRLD	0	Monthly

Detailed Field Definitions

HIB	Recipient's Medicare number on the Buy-In Part A Billing tape.
Last	Recipient's last name on the Buy-In Part A Billing tape.
First	Recipient's first name on the Buy-In Part A Billing tape.
MI	Recipient's middle initial on the Buy-In Part A Billing tape.
Sex	Identifies recipient's numeric sex code on the Buy-In Part A Billing tape.
Agency Cde	Identifies the three-character alphanumeric code on the Buy-In Part A Billing tape that CMS has assigned each state. Refer to the Buy-In manual for agency codes.
Billing Date	A four-character numeric code which identifies the month the State is billed for a recipient's Buy-In Part A premiums as displayed on the Buy-In Part A Billing tape.

TXN	The first two characters of the four-character code describing CMS's most recent response to State accretion, deletion, or changed records as shown on the Buy-In Part A Billing tape. The last two characters are the modifier code, which describes the State and/or EDS action for that recipient (accretion, deletion, or charge). Refer to the Buy-In manual for the transaction codes.
Eff Date	The effective date of the transaction when the recipient was accreted, deleted, or changed in Buy-In Part A (mmyy) as shown on the Buy-In Part A Billing tape.
RID	Recipient's 12-character numeric identification number on the Buy-In Part A Billing tape. This number always has QDWI as the last four characters of the RID.
Premium Amt	A six-character numeric code describing the Buy-In Part A premium amount billed by CMS to the State for a recipient's Buy-In Part A premiums.
Total Count	The number of QDWI recipients on the Buy In Part A Billing report.

```
 Report:  BIA-1008-M                                        IndianaAIM                                      Run Date:  MM/DD/CCYY
 Process:                                                                                                        Run Time:  HH:MM
 Location:                                  BUY-IN PART A QUALIFIED WORKING INDIVIDUALS                         Page:      99,999


                                                              AGENCY    BILLING                                          PREMIUM
     HIB             LAST              FIRST        MI   SEX    CDE      DATE      TXN     EFF DATE         RID          AMOUNT

xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00
xxxxxxxxxxxx     xxxxxxxxxxxx         xxxxxxx        X    X     XXX      mmyy     XXXX       mmyy       XXXXXXXXXXXX    9,999.00



 TOTAL COUNT:       999,999,999,999


                                                       * * END OF REPORT * *

                                                     * * NO DATA THIS RUN * *
```

Section 5: BIB Reports

BIB-2001-M Buy-In Part B Billing (Receiving)

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2001-M		Buy-In Part B Billing (Receiving)

Description of Information

The Buy-In Part B Billing report is a paper copy of the system-generated monthly tape from CMS. This report informs the OMPP of the status of the Buy-In Part B Medicaid members, using transaction codes to communicate an update or acknowledgment to a member Buy-In Part B status (accretion, deletion, or change).

Purpose

The purpose of the Buy-In Part B Billing report is to display CMS's current full listing of Buy-In Part B Billing records and acknowledgments of State accretion, deletion, and changed records.

Sort Sequence

- *Primary* - HIB number (Social Security claim numbers), in ascending order with left justification. The RRB numbers retain their Pseudo Social Security number and are not converted to the RRB claim numbers.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Member's Medicare number on the Buy-In Part B Billing Tape.
Last	Member's Medicare number on the Buy-In Part B Billing Tape.
First	Member's first name on the Buy-In Part B Billing Tape
MI	Member's first name on the Buy-In Part B Billing Tape
Sex	Identifies member's numeric sex code on the Buy-In Part B Billing Tape.
Birth/New HIB	This field contains either the member's date of birth (mmddyy) or the new HIB on the Buy-In Part B Billing Tape. Also, this position may contain an alphabetic character if CMS shows a different DOB. This alphabetic character equals the new number, for example1=A, 2=B, and so on

Liv Arg	A one-character alphabetic code of **D** that indicates that the beneficiary is a resident of a Title XIX institution. This field is applicable to deletion records. This is also the last character of a new HIB number.
Sts Cde	A one-character alphanumeric code that indicates the member's SSI status. Refer to the Buy-In Manual for Status Code description
Agency Cde	Identifies the three-character numeric code on the Buy-In Part B Billing Tape that CMS assigned each state. Refer to the Buy-In Manual for valid values.
Elig Cde	Identifies the one-character numeric code used to describe the category of assistance the member is receiving. Refer to the Buy In Manual for valid values
Sub	Identifies a one character alphanumeric code on the Buy In Part B Billing Tape that conveys additional information in conjunction with designated transaction codes. Refer to the Buy In Manual for valid values
Agency/Date	The Agency/Date field may contain the Sub Code effective date, (mmyy) which is found next to the sub code on the Billing B Tape. This same field may also have a three character numeric agency code for another state on the Billing B Tape.
Billing Dte	A four character numeric code that identifies the month and year (mmyy) the OMPP is billed for a member's premiums as displayed on the Buy In Part B Billing Tape
Txn	The first two characters of the four-character code describes CMS's most recent response to State accretion, deletion, or changed records as shown on the Buy-In Part B Billing Tape. The second two characters show what the State and EDS sent to CMS for accretion, deletion, or changed records. The second two characters on the transaction codes may be zeros or blank. Refer to the Buy-In Manual for valid values.
Eff Date	The effective date of the transaction on which the member was accreted, deleted, or changed in Buy In Part B as shown on the Buy In Part B Billing Tape. This field may be blank.
RID	Member's 12 character numeric identification number on the Buy In Part B Billing Tape. This field may be all zeros or an invalid number sent by CMS
Premium Amount	A six character numeric premium description for the amount billed by CMS to the State for a recipient's Buy In Part B premiums
Normal Billing	This includes all 41bb transaction codes from the Billing Tape. The 41bb (41__) is an ongoing Buy In Part B member. CMS has already bought this member in and continues to bill IFSSA for each month's premium.
Total Accretions	The enrollment of a member in the Buy In Part B Program. Total number of accretions on the Buy-In Part B Billing Tape. The accretion codes are 11XX, and 43XX. Refer to the Buy-In Manual for the transaction codes

Total Deletions	The removal of a member from the Buy In Part B Program. Total number of deletions on the Buy In Part B Billing Tape. The deletion codes are 14XX, 15XX, 16XX, 17XX, 42bb, and 42XX Refer to the Buy In Manual for the transaction codes.
Total Miscellaneous	Total number of all other transaction codes that are not accretions or deletions on the Buy-In Part B Billing Tape. Refer to the Buy-In Manual for the transaction codes.
Total Number Of Records Received From HCFA	Summary of all Normal Billings (accretions, deletions, and miscellaneous) sent by HCFA on the Buy-In Part B Billing Tape and received by IFSSA.
Debits	Charges to the State for member's Part B Premiums. The transaction codes used by CMS to inform the State that members have been bought in is transaction code (41bb), are in the process of being bought in transaction code (11XX), or are having a debit adjustment transaction code (43XX) for these members. Refer to the Buy-In Manual for the transaction codes.
Items	The total number of records for each debit transaction code appearing on the billing tape.
Money	The total number of records for each debit transaction code appearing on the billing tape.
Total	Total number of records for all credit transaction codes appearing on the billing tape
Credits	Credits to the State's Part B Buy In account for previous premiums paid in error. The transaction codes used by CMS to inform the State that they have overpaid a member’s Part B premiums are: 14XX, 15XX, 16XX, 17XX, 42bb, and 42XX. Refer to the Buy In Manual for the transaction codes.
Items	The total number of records for each credit transaction code appearing on the billing tape.
Money	The total dollar amount for each credit transaction code appearing on the billing tape.
Total	The total dollar amount for each credit transaction code appearing on the billing tape.
Miscellaneous	These are transaction codes used by CMS to inform the State of errors on the previous months Premium 150/S15 tape and various changes in CMS's records, on the status of a case. The miscellaneous codes are the following: 20XX, 21XX, 22XX, 23XX, 24XX, 25XX, 27XX, 28XX, 29XX, 30XX, 31XX, 32XX, 33XX, 49XX, 86XX, and 87XX. Refer to the Buy-In Manual for the transaction codes.
Items	The total number of records for each miscellaneous transaction code appearing on the billing tape.
Total	Total number of records for all credit transaction codes appearing on the billing tape.

HCFA Premium Dollars Billed	An accounting of the total dollar amount billed by HCFA.
Debits	Total dollar amount CMS bills IFSSA for Part B Premiums. This amount equals the **Total Debit** mentioned above.
Credits	The total dollar amount CMS credits IFSSA for Part B Premium. This amount equals the **Total Credit** mentioned above.
Total Billed	The total dollar amount CMS bills IFSSA for Buy-In Part B premiums, which equals the debits minus the credits.

```
    Report:  BIB-2001-M                                           IndianaAIM                                          Run Date:  MM/DD/CCYY
    Process:                                                                                                               Run Time:  HH:MM
    Location:                                          BUY-IN PART B BILLING (RECEIVING)                                  Page:      99,999



                                                 BIRTH/  LIV STS AGENCY  ELIG  SUB  AGENCY BILLING                                   PREMIUM
     HIB          LAST        FIRST    MI  SEX  NEW HIB  ARG CDE   CDE    CDE        DATE    DATE    TXN   EFF DATE      RID          AMOUNT

999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99
999999999999  XXXXXXXXXXXX   XXXXXXX   X    9    mmddyy   X   X    999     X    X    9999    mmyy    9999    mmyy    999999999999   $9,999.99

        NORMAL BILLING:                                 99,999,999
        TOTAL ACCRETIONS:                               99,999,999
        TOTAL DELETIONS:                                        99,999,999
        TOTAL MISCELLANEOUS:                            99,999,999

        TOTAL NUMBER OF RECORDS RECEIVED FROM HCFA:     99,999,999
```

Report: BIB-2001-M Indiana*AIM* Run Date: MM/DD/CCYY
Process: Run Time: HH:MM
Location: BUY-IN PART B BILLING (RECEIVING) Page: 99,999

BUY-IN STATISTICS SUMMARY

	DEBITS			CREDITS			MISCELLANEOUS	
	ITEMS	MONEY		ITEMS	MONEY		ITEMS	MONEY
CODE 11	99,999	99,999	CODE 14	99,999	99,999	CODE 20	99,999	99,999
CODE 41	99,999	99,999	CODE 15	99,999	99,999	CODE 21	99,999	99,999
CODE 43	99,999	99,999	CODE 16	99,999	99,999	CODE 22	99,999	99,999
			CODE 17	99,999	99,999	CODE 23	99,999	99,999
			CODE 42	99,999	99,999	CODE 24	99,999	99,999
						CODE 25	99,999	99,999
						CODE 27	99,999	99,999
						CODE 28	99,999	99,999
						CODE 29	99,999	99,999
						CODE 30	99,999	99,999
						CODE 31	99,999	99,999
						CODE 32	99,999	99,999
						CODE 33	99,999	99,999
						CODE 49	99,999	99,999
						CODE 86	99,999	99,999
						CODE 87	99,999	99,999
						CODE 90	99,999	99,999
TOTAL	9,999,999	9,999,999		9,999,999	9,999,999		9,999,999	9,999,999
							TOTAL:	9,999,999

HCFA PREMIUM DOLLARS BILLED

DEBIT	999,999
CREDIT	999,999
TOTAL BILLED	9,999,999

* * END OF REPORT * *

* * NO DATA THIS RUN * *

BIB-2002-M Buy-In Part B Premium 150 (Sending)

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2002-M		Buy-In Part B Premium 150 (Sending)

Description of Information

The Buy-In Part B Premium 150 report is a paper copy of the accretion, deletion, or changes made to Buy-In Part B recipients by the State or EDS in a given month. These updates are sent to CMS by a monthly tape so CMS may respond to each entry.

Purpose

The purpose of the Buy-In Part B Premium 150 report is to notify CMS of any recipient updates (accretion, deletion, or changes) after the monthly Buy-In Part B Billing tape is run.

Sort Sequence

- *Primary -* HIB number (Social Security claim numbers), ascending with left justification.

> *Note: RRB numbers retain their Pseudo Social Security number and do not convert to the RRB claim numbers.*

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Member's Medicare number on the Buy-In Part B Premium 150 Tape sent to
Last	Member's last name on the Buy-In Part B Premium 150 Tape.
First	Member's first name on the Buy-In Part B Premium 150 Tape.
MI	Member's middle initial on the Buy-In Part B Premium 150 Tape.
Sex	Identifies member's numeric sex code on the Buy-In Part B Premium 150 Tape
Birth	Member's date of birth (mmddyy) on the Buy-In Part B Premium 150 Tape.
ZIP	Member's date of birth (mmddyy) on the Buy-In Part B Premium 150 Tape.

Agency Code	Identifies the three-character numeric code on the Buy-In Part B Premium 150 Tape. Refer to the Buy-In Manual for valid values.
Elig Code	Identifies the one-character numeric code used to describe the category of assistance the member is receiving. Refer to the Buy-In Manual for valid values.
Txn	The two-character numeric code sent to CMS indicating an EDS or IFSSA update (accretion, deletion, or changed) requiring a response by CMS. Refer to the Buy-In Manual for valid values.
Eff Date	The effective date (mmyy) needed for the transaction sent on the Buy-In Part B Premium 150 Tape
RID	Member's 12-character numeric identification number on the Buy-In Part B Premium 150 Tape.
Total Accretions	Total number of accretions made by EDS or IFSSA and sent to CMS on the Buy-In Part B Premium 150 Sending Tape. The accretion transaction codes are as follows: 61, 62, 63, 75, and 84.
Total Deletions	Total number of deletions made by EDS or IFSSA and sent to CMS on the Buy-In Part B Premium 150 sending Tape. The deletion transaction codes are as follows: 50, 51, 53, and 76
Total Changes	Total number of changes made by EDS or IFSSA and sent to CMS on the Buy-In Part B Premium 150 Sending Tape. The change transaction code is 99.
Summary of Records Sent To HCFA	Summary of all accretions, deletions, and changes done by EDS or IFSSA and sent to HCFA on the Buy-In Part B Premium 150 Sending Tape.

```
Report:  BIB-2002-M                              IndianaAIM                                 Run Date:  MM/DD/CCYY
Process:                                     Run Time:  HH:MM
Location:                             BUY-IN PART B PREMIUM 150 (SENDING)                     Page:      99,999


                                                                          AGENCY    ELIG          EFF
    HIB             LAST          FIRST      MI     SEX      BIRTH        ZIP        CODE      CODE    TXN   DATE         RID

 999999999999   xxxxxxxxxxxx    xxxxxxx      X       9      mmddyy       99999        999        X      99   mmyy   999999999999
 999999999999   xxxxxxxxxxxx    xxxxxxx      X       9      mmddyy       99999        999        X      99   mmyy   999999999999
 999999999999   xxxxxxxxxxxx    xxxxxxx      X       9      mmddyy       99999        999        X      99   mmyy   999999999999
 999999999999   xxxxxxxxxxxx    xxxxxxx      X       9      mmddyy       99999        999        X      99   mmyy   999999999999
 999999999999   xxxxxxxxxxxx    xxxxxxx      X       9      mmddyy       99999        999        X      99   mmyy   999999999999
 999999999999   xxxxxxxxxxxx    xxxxxxx      X       9      mmddyy       99999        999        X      99   mmyy   999999999999


    TOTAL ACCRETIONS:                       99,999,999
    TOTAL DELETIONS:                                99,999,999
    TOTAL CHANGES:                          99,999,999

    SUMMARY OF RECORDS SENT TO HCFA:                99,999,999


                                              * * END OF REPORT * *

                                             * * NO DATA THIS RUN * *
```

BIB-2003-M Buy-In Part B Exception Error By HIB

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2003-M		Buy-In Part B Exception Error By HIB

Description of Information

The Buy-In Part B Exception Error By HIB Report contains records from the Billing Tape that need to be reviewed for different reasons. The following transaction codes always appear on the Buy-In Part B Exception Error By HIB report: 1125, 1128, 1165,1167, 1725, 1728, 18XX, 19XX, 20XX, 21XX, 22XX, 24XX, 25XX, 27XX, 28XX, 29XX, 30XX, 31XX, 32XX, 33XX, and 3662. The Buy-In Part B Transaction Codes definition indicates the additional codes that trigger certain records to appear on the Buy-In Part B Exception Error By HIB Report. See the *Buy-In Part A Transaction Code* document for more details.

Purpose

The purpose of the Buy-In Part B Exception Error By HIB Report is to identify the above listed codes from CMS. EDS and IFSSA review, research and resolve any problems associated with these codes.

Sort Sequence

- *Primary -* HIB number – All Railroad Retirement Board (RRB) numbers, numbers with a prefix, are grouped after the Social Security claim number (numbers with a suffix). Railroad numbers are listed with the prefix sorted alphabetically and the numeric portion of the number in ascending order with left justification. RRB numbers retain their original number.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
IFSSA	CRLD/Paper	2	Monthly

Detailed Field Definitions

HIB	Member's Medicare number on the Buy-In Part B Billing Tape.
Last	Member's last name on the Buy-In Part B Billing Tape
First	Member's first name on the Buy-In Part B Billing Tape
MI	Member's middle initial on the Buy-In Part B Billing Tape.
Sex	Identifies a member's numeric sex code on the Buy-In Part B Billing Tape.
Birth/New HIB	This field contains either the member's date of birth (mmddyy) or the new HIB on the Buy-In Part B Billing Tape. Also, this position may contain an alphabetic character if CMS shows a different DOB.

Liv Arg	A one-character alphabetic code of D which indicates that the beneficiary is a resident of a title XIX institution. This field is applicable to deletion records. This is also the last character of a new HIB number.
Sts Cde	A one-character alphanumeric code that indicates the member's SSI status. Refer to the Buy-In manual for Status Code description.
Agency Cde	Identifies the three-character numeric code on the Buy-In Part B Billing Tape that CMS has assigned each state. Refer to the Buy-In manual for valid values.
Elig Cde	Identifies the one-character numeric code used to describe the category of assistance the member is receiving. Refer to the Buy-In manual for valid values
Sub	Identifies a one character alphanumeric code on the Buy In Part B Billing Tape that conveys additional information in conjunction with designated transaction codes. Refer to the Buy In manual for valid values.
Agency/Date	The Agency/Date field may contain the Sub Code effective date (mmyy) which is found next to the sub code on the Billing B Tape. This same field may also have a three character numeric agency code, for another state on the Billing B Tape.
Billing Date	A four character numeric code which identifies the month and year (mmyy) the State is billed for a member's premiums as displayed on the Buy In Part B Billing Tape
Txn	The first two characters of the four character code describes CMS's most recent response to the OMPP accretion, deletion, or changed records as shown on the Buy-In Part B Billing Tape. The second two characters show what the OMPP and EDS sent to CMS for accretion, deletion, or changed records. The second two characters on the transaction codes may be zeros or blank. Refer to the Buy In manual for valid values.
Eff Date	The effective date of the transaction on which the recipient was accreted, deleted, or changed in Buy-In Part B as shown on the Buy-In Part B Billing Tape. This field may be blank.
RID	Member's 12-character numeric identification number on the Buy-In Part B Billing Tape. This field may be all zeros or an invalid number sent by CMS.
Premium Amt.	A six-character numeric code describing the premium amount billed by CMS to the OMPP for a member's Buy-In Part B premiums.
Error Code	A two-character numeric code further describing transaction code errors that CMS has sent in response to the OMPP accretions, deletions, and changes.

```
    Report:  BIB-2003-M                                                IndianaAIM                                              Run Date:
    MM/DD/CCYY
    Process:                                                                                                           Run Time:  HH:MM
    Location:                                       BUY-IN PART B EXCEPTION ERROR BY HIB                               Page:      99,999



                                          BIRTH/  LIV STS  AGENCY ELIG  SUB  AGENCY BILLING                             PREMIUM       ERROR
    HIB           LAST      FIRST  MI SEX NEW HIB ARG CDE   CDE   CDE         DATE   DATE   TXN   EFF DATE    RID        AMOUNT        CODE

999999999999  XXXXXXXXXXXX XXXXXXX X  9  mmddyy   X   X    999    X     X    9999   mmyy   9999    mmyy   999999999999  $9,999.99      99
999999999999  XXXXXXXXXXXX XXXXXXX X  9  mmddyy   X   X    999    X     X    9999   mmyy   9999    mmyy   999999999999  $9,999.99      99
999999999999  XXXXXXXXXXXX XXXXXXX X  9  mmddyy   X   X    999    X     X    9999   mmyy   9999    mmyy   999999999999  $9,999.99      99
999999999999  XXXXXXXXXXXX XXXXXXX X  9  mmddyy   X   X    999    X     X    9999   mmyy   9999    mmyy   999999999999  $9,999.99      99


                                                             * * END OF REPORT * *

                                                           * * NO DATA THIS RUN * *
```

BIB-2004-M Buy-In Part B Exception Error By Transaction Code

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2004-M		Buy-In Part B Exception Error By Transaction Code

Description of Information

The Buy-In Part B Exception Error By Transaction Code Report contains records from the Billing Tape that need to be reviewed for different reasons. The following transaction codes always appear on the Buy-In Part B Exception Error By Transaction Code Report: 1125, 1128, 1165, 1167, 1725, 1728, 18XX, 19XX, 20XX, 21XX, 22XX, 24XX, 25XX, 27XX, 28XX, 29XX, 30XX, 31XX, 32XX, 33XX, and 3662. The Buy-In Part B transaction codes definition indicates the additional codes that trigger certain records to appear on the Buy-In Part B Exception Error By Transaction Code Report. Refer to the Buy-In Part A Transaction Code document for more details.

Purpose

The purpose of the Buy-In Part B Exception Error By Transaction Codes Report is to identify the above listed codes from CMS. EDS and IFSSA review, research and resolve any problems associated with these codes.

Sort Sequence

- *Primary -* Transaction codes (the first two digits) and modifier (the last two digits) in numeric order.

The system inserts a break between the different transaction codes (first two digits). The one exception is transaction code 1167. All the 1167 transaction codes are listed on a separate page. After the report is sorted in transaction code order, the system sorts by HIB number in each transaction and modifier code. Sort the Social Security claim numbers (HIB) are sorted in ascending order with left justification. All Railroad Retirement Board (RRB) numbers (numbers with a prefix) are grouped after the Social Security claim number (numbers with a suffix). Railroad numbers are listed with the prefix sorted alphabetically. The numeric portion of the number is in ascending order with left justification. RRB numbers retain their original numbers.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
IFSSA	CRLD/Paper	2	Monthly

Detailed Field Definitions

TXN

The first two characters of the four character code describes CMS's most recent response to the OMPP accretion, deletion, or changed records as shown on the Buy-In Part B Billing Tape. The second two characters show

	what the OMPP and EDS sent to CMS for accretion, deletion, or changed records. The second two characters on the transaction codes may be zeros or blank. Refer to the Buy In manual for valid values.
HIB	Member's Medicare number on the Buy-In Part B Billing Tape.
Last	Member's last name on the Buy-In Part B Billing Tape
First	Member's first name on the Buy-In Part B Billing Tape
MI	Member's middle initial on the Buy-In Part B Billing Tape.
Sex	Identifies member's numeric sex code on the Buy-In Part B Billing Tape.
Birth/New HIB	This field contains either the member's date of birth (mmddyy) or the new HIB on the Buy-In Part B Billing Tape. This position may contain an alphanumeric character if CMS shows a different DOB.
Liv Arg	A one-position alphabetic code of **D** that indicates that the beneficiary is a resident of a Title XIX institution. This field is applicable to deletion records. This is also the last character of a new HIB number.
Status Code	A one-position alphanumeric code that indicates the member's SSI status. Refer to the Buy-In manual for Status Code description.
Agency Code	Identifies the three character numeric code on the Buy In Part B Billing Tape that CMS has assigned each state. Refer to the Buy In manual for valid values.
Elig Code	Identifies the one character numeric code used to describe the category of assistance the member is receiving. Refer to the Buy In manual for valid values.
Sub	Identifies a one character alphanumeric code on the Buy In Part B Billing Tape that conveys additional information in conjunction with designated transaction codes. Refer to the Buy In manual for valid values
Agency/Date	The Agency/Date field may contain the sub-code effective date (mmyy) which is found next to the sub-code on the Billing B Tape. This same field may also have a three-character numeric agency code for another state on the Billing B Tape.
Billing Dte	A four character numeric code which identifies the month and year (mmyy) the OMPP is billed for a member's premiums as displayed on the Buy In Part B Billing Tape.
Eff Date	The effective date of the transaction on which the member was accreted, deleted, or changed in Buy-In Part B as shown on the Buy-In Part B Billing Tape. This field may be blank.
RID	Recipient's 12-character numeric identification number on the Buy-In Part B Billing Tape. This field may be all zeros or an invalid number sent by CMS.
Premium Amt.	A six-character numeric code describing the premium amount billed by CMS to the State for a member's Buy-In Part B premiums.

Error Code	A two character numeric code further describing transaction code errors that CMS has sent in response to the OMPP accretions, deletions, and changes.

Report: BIB-2004-M Indiana*AIM* Run Date: MM/DD/CCYY
Process: Run Time: HH:MM
Location: BUY-IN PART B EXCEPTION ERROR BY TRANSACTION CODE Page: 99,999

TXN	HIB	LAST	FIRST	MI	SEX	BIRTH/ NEW HIB	LIV ARG	STS CDE	AGENCY CODE	ELIG CODE	SUB	AGENCY /DATE	BILLING DATE	EFF DATE	RID	PREMIUM AMOUNT	ERROR CODE
9999	999999999999	XXXXXXXXXXXX	XXXXXXX	X	9	mmddyy	X	X	999	X	X	9999	mmyy	mmyy	999999999999	$9,999.99	99

* * END OF REPORT * *

* * NO DATA THIS RUN * *

BIB-2005-M Buy-In Part B Specified Low Income Medicare Beneficiaries (SLMB) Billing Transactions

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2005-M		Buy-In Part B Specified Low Income Medicare Beneficiaries (SLMB) Billing Transactions

Description of Information

The Buy-In Part B SLMB (Specified Low Income Medicare Beneficiaries) Billing Transactions Report is a listing from the Buy-In Part B Billing Tape of those individuals accreted, deleted, or changed on the SLMB program Buy-In Part B. These individuals are only eligible to have their premiums paid by the OMPP.

Purpose

The purpose of the Buy-In Part B SLMB Report is to identify the members in the SLMB program in Buy-In Part B.

Sort Sequence

- *Primary -* HIB number – All Railroad Retirement Board (RRB) numbers (numbers with a prefix) are grouped before the Social Security claim numbers (numbers with a suffix).

Railroad numbers are listed with the prefix sorted alphabetically and the numeric portion of the number sorted in ascending order with left justification. RRB numbers retain their original numbers and do not convert to a Pseudo Social Security Number. Refer to the Buy-In manual for valid values. The Social Security claim number (HIB) sort in ascending order with left justification.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Member's Medicare number on the Buy-In Part B Billing Tape.
Last	Member's last name on the Buy-In Part B Billing Tape
First	Member's first name on the Buy-In Part B Billing Tape
MI	Member's middle initial on the Buy-In Part B Billing Tape.
Sex	Identifies member's numeric sex code on the Buy-In Part B Billing Tape.

Birth/New HIB	This field contains either the member's date of birth (mmddyy) or the new HIB on the Buy-In Part B Billing Tape. This position may contain an alphabetic character if CMS shows a different DOB.
Liv Arg	A one-position alphabetic code of **D** that indicates that the beneficiary is a resident of a title XIX institution. This field is applicable to deletion records. This is also the last character of a new HIB number.
Sts Cde	A one-character alphanumeric code that indicates the member's SSI status. Refer to the Buy-In manual for Status Code description.
Agency Cde	Identifies the three-character numeric code on the Buy-In Part B Billing Tape that CMS has assigned to each state. Refer to the Buy-In manual for valid values.
Elig Cde	Identifies the one-character numeric code used to describe the category of assistance the member is receiving. Refer to the Buy-In manual for valid values.
Sub	Identifies a one character alphanumeric code on the Buy In Part B Billing Tape that conveys additional information in conjunction with designated transaction codes. Refer to the Buy In manual for valid values
Agency/Date	The Agency/Date field may contain the sub-code effective date (mmyy) which is found next to the sub-code on the Billing B Tape. This same field may also have a three-character numeric agency code for another state on the Billing B Tape.
Billing Date	A four-character numeric code which identifies the month and year (mmyy) the OMPP is billed for a member's premiums as displayed on the Buy-In Part B Billing Tape.
Txn	The first two characters of the four character code describes CMS's most recent response to the OMPP accretion, deletion, or changed records as shown on the Buy-In Part B Billing Tape. The second two characters show what the OMPP and EDS sent to CMS for accretion, deletion, or changed records. The second two characters on the transaction codes may be zeros or blank. Refer to the Buy In manual for valid values
Eff Date	The effective date of the transaction on which the member was accreted, deleted, or changed in Buy-In Part B as shown on the Buy-In Part B Billing Tape. This field may be blank
RID	Member's 12-character numeric identification number on the Buy-In Part B Billing Tape. This field may be all zeros or an invalid number sent by CMS.
Premium Amount	A six-character numeric code describing the premium amount billed by CMS to the OMPP for a member's Buy-In Part B premiums.
Total	The number of SLMB members on the Buy-In Part B Billing report.

```
    Report:  BIB-2005-M                                           IndianaAIM                                          Run Date:  MM/DD/CCYY
    Process:                                                                                                               Run Time:  HH:MM
    Location:                          BUY-IN PART B SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB)                   Page:      99,999


                                               BIRTH/  LIV STS  AGENCY  ELIG  SUB  AGENCY   BILLING                                   PREMIUM
     HIB          LAST       FIRST   MI  SEX  NEW HIB  ARG CDE    CDE    CDE        DATE     DATE     TXN    EFF DATE      RID         AMOUNT

999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99
999999999999  XXXXXXXXXXXX  XXXXXXX  X    9   mmddyy    X   X     999    X    X     9999     mmyy     9999     mmyy    999999999999  $9,999.99



    TOTAL:                  999,999,999

                                                             * * END OF REPORT * *

                                                           * * NO DATA THIS RUN * *
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BIB-2006-M Buy-In Part B Pending Transactions Awaiting 3 Months Reply

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2006-M		Buy-In Part B Pending Transactions Awaiting 3 Months Reply

Description of Information

The Buy-In Part B Pending Transaction Awaiting 3 Months Reply shows the Buy-In Part B Premium 150 entries sent to CMS and did not have a response. The transaction codes included on this report are as follows: 61 (normal accretion), 62 (second accretion sent), 63 (accretion code used for testing), 50 (system generated deletion in response to an 1165), 51 (normal delete), 53 (death delete), and 75/76 (simultaneous accrete/delete). Included with this transaction code is the date that the entry was sent to CMS. The transaction code 4999 from CMS does not qualify as a response because 4999 transactions codes are CMS acceptance or changes for current Buy-In members, and do not affect accretions nor deletions of Buy-In.

Purpose

The purpose of the Buy-In Part B Pending Transactions Awaiting 3 Months Reply is to indicate to IFSSA and EDS which members CMS has not responded to within the last three months.

Sort Sequence

- *Primary* - HIB number – All Railroad Retirement Board (RRB) numbers (numbers with a prefix, are grouped before the Social Security claim number (numbers with a suffix). Railroad numbers are listed with the prefix, sorted alphabetically, and with the numeric portion of the number in ascending order with left justification. RRB numbers retain their original number. Refer to the Buy-In manual for valid values.
- *Secondary* - Social Security claim number in ascending order with left justification.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

HIB	Member's Medicare number on the Buy-In Part B Premium tape
Last	Member's last name on the Buy-In Part B Premium tape
First	Member's first name on the Buy-In Part B Premium tape
MI	Member's middle initial on the Buy-In Part B Premium tape

Sent Txn	The two character numeric code sent to CMS indicating an EDS or IFSSA update (accretion, deletion, change) needing a response from CMS. This is also called the Modifier portion of the transaction code. The transaction codes included on this report are as follows: 61 (normal accretion), 62 (second accretion sent), 63 (identifies Alert State test members), 50 (system generated deletion response to an 1165), 51 (normal delete), 53 (death delete), and 75/76 (simultaneous accrete delete).
Sent Dte	The date the transaction was sent to CMS on the Buy-In Part B Premium 150 tape.
Eff Date	The effective date the member needs the action with the transaction code taken.
Rcvd Txn	The four character numeric code received from CMS indicating to EDS or IFSSA the information sent is awaiting a response at a later date. The transaction codes included on the report are as follows: 3061 (CMS adjusting buy in effective date to a later date), 3062 (CMS adjusting buy in effective date to a later date), 3063 (CMS adjusting buy in effective date to a later date), 3151 (CMS delaying deletion), 3153 (CMS delaying deletion), 3161 (CMS delaying accretion), 3162 (CMS delaying deletion), 3163 (CMS delaying accretion), 3184 (CMS delaying accretion), 3261 (CMS rejecting accretion), 3263 (CMS rejecting accretion), 3275 (CMS rejecting accretion), and 3276 (CMS rejecting accretion).
Rcvd date	The date (mmyy) the transaction was received from CMS on the Buy-In Part A premium S15 Tape.

```
Report:  BIB-2006-M                        IndianaAIM                          Run Date:
                     MM/DD/CCYY
Process:                                                                       Run Time:  HH:MM
Location:                        BUY-IN PART B PENDING TRANSACTIONS            Page:      99,999
                                      AWAITING 3 MONTHS REPLY


       HIB                LAST                FIRST          MI       SENT       SENT       EFF        RCVD       RCVD
                                                                      TXN        DATE       DATE       TXN        DATE

  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy
  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy
  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy
  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy
  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy
  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy
  XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX          X        99        mmyy       mmyy       9999       mmyy




                                       * * END OF REPORT * *

                                      * * NO DATA THIS RUN * *
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BIB-2007-M Buy-In Part B Control Report

Functional Area	Report Number	Job Name	Report Title
Buy-In	BIB-2007-M		Buy-In Part B Control Report

Description of Information

The Buy-In Part B Control report identifies the Medicare Part B premium amount billed to the State by CMS for the current billing month. The billing month is the month following the month the Billing Tape is received. This report reflects the amount billed and divides the amounts by the category of assistance which qualify for Part B Buy-In. **QMB** and **SLMB** are both divided into **Also** and **Only**. **Money Grant** is divided into **Money Grant** and **Non-Money Grant**. There is an **Unknown** category for recipients without a RID number. The aid category for **QMB Only** is **MA L** or **MALP**. The aid category for **SLMB Only** is **MA J**. The **QMB Also** and **SLMB Also** include one of the following aid categories: **Aged, Blind, Disabled, AFDC**. The **Money Grant** and **Non-Money Grant** categories include one of the following aid categories: **Aged**, **Blind, Disabled, AFDC**, **Medicaid for Pregnant Women**, **Medicaid for Children,** and **Medicaid for Newborns**.

Premium Totals include the **Premium Balance** that CMS is billing for each category and a **Combined Total**. The **Combined Total** may equal the **CMS Premium Dollars Billed,** which matches the paper copy of the actual billing tape output CMS sends to the OMPP. However, because CMS may send accretions that do not agree with EDS records, any discrepancies with the dollar amounts are researched.

This report further identifies the total number and total amount of premiums billed for the month. Current month and retroactive months totals are reported. Totals for the Federal Fiscal Year, State Fiscal Year, and Calendar Year are shown. The report also indicates the premium items paid that are eligible or not eligible for Federal Financial Participation (FFP). Premiums paid for QMB, SLMB, QI, and Money Grant members are eligible for FFP; premiums paid for all others (called Non-Money Grant) are not eligible for FFP. The order of FFP categories is: QMB, SLMB, Money Grant and QI. The last item on this report is the number of records received from CMS and sent to CMS, sorted by the different transaction codes.

Purpose

The purpose of the Buy-In Part B Control report is to reflect the amount CMS is billing IFSSA by category for Medicare Part B premiums in the given billing month and assists in the calculation of the amount to be paid to CMS for Medicare Part B Buy-In.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	2	Monthly

Detailed Field Definitions

Premiums Billed By Category	Is divided into FFP and NON FFP eligibility and identified by **QMB Also**, **SLMB Also**, **QMB/SLMB Only**, **Money Grant**, and **Non Money Grant**. These are further divided by the following member aid categories: **Aged, Blind**, **Disabled**, **AFDC**, **Medicaid for Pregnant Woman**, **Medicaid for Children,** and **Medicaid for Newborns**. These categories are interrelated in that each aid category is a sub-category of FFP eligibility or Non-FFP eligibility.
QMB Also	Category reflects Qualified Medicare Beneficiaries. Members may be **QMB Also** or **QMB Only**. The **QMB Only** member is entitled to payments of Medicare premiums and any Medicare co payments or deductibles. **QMB Also** members are entitled to the **QMB Only** benefits as well as IHCP benefits under one of the following aid categories: **Aged, Blind, Disabled**, or **AFDC**. The aid categories for all QMB members are **MA L**, or **MALP**. **QMB Also** members have two aid categories: **MA L**, or **MALP** and IHCP eligibility categories **Aged**, **Blind**, **Disabled**, or **AFDC**. To identify **QMB** members for this report, the system searches the Billing record for an eligibility code of **P** in position 50. Those without dual eligibility are included in this report under the column **QMB Only.** All others are included in the columns for **QMB Also**.
Category Header	Aid categories under the Medicare Part B Buy-In QMB program. The category headers are **QMB/Aged**, **QMB/Blind**, **QMB/Disabled**, **QMB/AFDC**, and **QMB Also Total**.
QMB/Blind	Members qualifying for QMB (Qualified Medicare Beneficiaries) plus IHCP under the **Blind** program. The following aid categories comprise **Blind** for this report: **MA B**, **MA 6**, **MABP**, and **MA6P**
QMB/Disabled	Members qualifying for QMB (Qualified Medicare Beneficiaries) plus IHCP under the Disabled program. The following aid categories comprise **Disabled** for this report: **MA D**, **MA R**, **MA 7**, **MADP**, **MARP**, and **MA7P**.
QMB/AFDC	Members qualifying for QMB (Qualified Medicare Beneficiaries) plus IHCP under the AFDC program. The following aid categories comprise AFDC for this report: **MA C**, **MA F**, **MA H**, **MA O**, **MA Q**, **MA S**, **MA T**, **MA U**, **MA 4**, **MA 8**, **MACP**, **MAFP**, **MAHP**, **MAOP**, **MASP**, **MATP**, **MAUP**, **MA4P**, and **MA8P**
QMB Also Total	The combined totals of the columns as follows: **QMB/Aged**, **QMB/Blind**, **QMB/Disabled**, and **QMB/AFDC**. Each of the above categories are divided into Normal Billing, Verified Accretions, Verified Deletions, and Balance depending upon the reported transaction codes.
Normal Billing	Includes all 41bb transaction codes from the Billing Part B tape for each **QMB** category. The 41bb (41__) is an ongoing Buy In Part B member. CMS has already bought in this member and continues to bill IFSSA for each month's premium. Refer to the Buy In manual for the transaction codes.

Verified Accretions	Includes all 11XX and 43XX transaction codes. The code 11XX means CMS has accepted the accretion attempt for this member for the effective date requested. A code 1167 means CMS is informing IFSSA this member is accreted for that effective date. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Verified Deletions	Includes all 15bb (15__), 16bb (16__), 17XX, 42bb (42__), and 42XX transaction codes. These codes mean CMS is stopping Buy In for a member for various reasons. These codes are a credit to IFSSA, or CMS is sending a credit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Balance	A balance is given for the total of the **Normal Billing** plus the **Verified Accretions** minus the **Verified Deletions** for each of the **QMB Also** categories as follows: **QMB/Aged**, **QMB/Blind**, **QMB/Disabled**, **QMB/AFDC**, and **QMB Also Total**.
SLMB Also	Reflects Specified Low Income Medicare Beneficiaries who are eligible for other IHCP assistance under one of the following aid categories: **Aged Blind Disabled** or **AFDC**. The aid categories for all SLMB members are **MA J** or **MAJP**. To identify **SLMB** members for this report, the system searches the Billing record for an eligibility code of **L** in position 50. Those without dual eligibility are included in this report under the column **SLMB Only**; all others are included in the columns for **SLMB Also**.
Category Header	Aid categories under the Medicare Part B Buy In SLMB program. The following are the category headers: **SLMB/Aged**, **SLMB/Blind**, **SLMB/Disabled**, **SLMB/AFDC**, and **SLMB Also Total**.
SLMB/Aged	Members qualifying for SLMB (Specified Low Income Medicare Beneficiaries) plus IHCP under the **Aged** program. The following aid categories comprise **Aged** for this report: **MA A**, **MA 5**, **MAAP**, and **MA5P**.
SLMB/Blind	Members qualifying for SLMB (Specified Low Income Medicare Beneficiaries) plus IHCP under the **Blind** program. The following aid categories comprise **Blind** for this report: **MA B**, **MA 6**, **MABP**, and **MA6P**.
SLMB/Disabled	Members qualifying for SLMB (Specified Low Income Medicare Beneficiaries) plus IHCP under the **Disabled** program. The following aid categories comprise **Disabled** for this report: **MA D**, **MA R**, **MA 7**, **MADP**, **MAGP**, **MARP**, and **MATP**.
SLMB/AFDC	Members qualifying for SLMB (Specified Low Income Medicare Beneficiaries) plus IHCP under the **AFDC** program. The following aid categories comprise **AFDC** for this report: **MA C**, **MA F**, **MA H**, **MA O**, **MA Q**, **MA S**, **MA T**, **MA U**, **MA 4**, **MA 8**, **MACP**, **MAFP**, **MAOP**, **MASP**, **MATP**, **MAUP**, **MA4P**, and **MA8P**.
SLMB Also Total	These are the combined total of the columns as follows: **MB/Aged**, **QMB/Blind**, **QMB/Disabled**, and **QMB/AFDC** Each of the above categories are divided into Normal Billing, Verified Accretions, Verified Deletions, and Balance – depending on the reported transaction codes.
Normal Billing	Includes all 41bb transaction codes from the Billing Buy In Part B tape for each SLMB category. The 41bb (41__) is an ongoing Buy In Part B member. CMS has already bought in this member and continues to bill IFSSA for each month's premiums. Refer to the Buy In manual for the transaction codes.

Verified Accretions	Includes all 11XX and 43XX transaction codes. The code 11XX means CMS has accepted the accretion attempt for this member for the effective date requested. A code 1167 means CMS is informing IFSSA this member is accreted for that effective date. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy-In manual for the transaction codes.
Verified Deletions	Includes all 15bb (15__), 16bb (16__), 17XX, 42XX, and 42bb (42__) transaction codes. These codes mean CMS is stopping Buy In for a member for various reasons. These codes are a credit to IFSSA or CMS is sending a credit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Balance	Given for the total of the **Normal Billing** plus the **Verified Accretions** minus the **Verified Deletions** for each of the **SLMB** categories. Categories are as follows: **SLMB/Aged**, **SLMB/Blind**, **SLMB/Disable**, **SLMB/AFDC**, and **SLMB Also Total**.
QMB/SLMB/QI Only	Category reflects members who are not eligible for Medicaid, but are eligible for Medicare Part B Buy In premiums paid by IFSSA.
Category Header	Aid categories under the Medicare Part B Buy In program. The following are the category headers: **QMB Only** and **SLMB Only**.
QMB Only	Qualified Medicare Beneficiaries who are not eligible for IHCP but are entitled to have Medicaid B Premiums and Medicare co-payments or deductibles paid by IFSSA. These members have the following aid categories: **MA L** and **MALP**.
SLMB Only	Specified Low Income Medicare Beneficiaries are only entitled to Medicare Part B premiums paid by IFSSA.
QI Only	Qualified Individuals are entitled to Medicare Part B premiums paid by IFSSA. These individuals are identified by Aid Category **MA I**.

Each of the above categories are divided into Normal Billing, Verified Accretions, Verified Deletions, and Balance depending on the reported transaction codes.

Normal Billing	Includes all 41bb transaction codes from the Billing Part B tape for each category. The 41bb (41__) is an ongoing Buy In Part B member. CMS has already bought in this member, and continues to bill IFSSA for each month's premium. Refer to the Buy In manual for the transaction codes.
Verified Accretions	Includes all 11XX and 43XX transaction codes. The code 11XX means CMS has accepted the accretion attempt for this member for the effective date requested. An 1167 means CMS is informing IFSSA this member is accreted for that effective date. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Verified Deletions	This includes all 15bb (15__), 16bb (16__), 17XX, 42XX, and 42bb (42__) transaction codes. These codes mean CMS is stopping a member's Buy In for various reasons. These codes are a credit to IFSSA, or CMS is sending a credit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Balance	A balance is given for the total of the **Normal Billing** plus the **Verified Accretions**, minus the **Verified Deletions** for each of the **QMB Only**, **SLMB Only** and **QI Only** categories.

Money Grant	Category reflects members who are in IHCP and receive all or part of their income from one or more of the following: SSI (Social Security)AFDC (Aid to Families with Dependent Children) RBA (Room and Board Administration) or State Supplement Assistance. The aid categories for Money Grant are as follows: **Aged Blind Disabled AFDC Medicaid for Pregnant Women Medicaid for Children Medicaid for Newborns** and **Money Grant Total** To identify **Money Grant** members for this report, a Money Grant indicator of **Yes** or **No** on the Recipient Base window identifies members with or without Money Grant status. This information is received from ICES. Those without dual eligibility are included in this report under the columns **Non-Money Grant**; all others are included in the columns for **Money Grant**.
Category Header	Aid categories under the Medicare part B Buy In Money Grant program. The category headers are: **Aged**, **Blind**, **Disabled**, **AFDC**, **Medicaid For Pregnant Women**, **Medicaid For Children**, **Medicaid For Newborns**, and **Money Grant Total**.
Aged	Members qualifying for Money Grant plus IHCP under the **Aged** program. The following aid categories comprise **Aged** for this report: **MA A**, **MA 5**, **MAAP**, and **MA5P**.
Blind	Members qualifying for Money Grant plus IHCP under the Blind program. The following aid categories comprise **Blind** for this report: **MA B**, **MA 6**, **MABP**, and **MA6P**.
Disabled	Members qualifying for Money Grant plus Medicaid under the Disabled program. The following aid categories comprise **Disabled** for this report: **MA D**, **MA R**, **MA 7**, **MADP**, **MAGP**, **MARP**, and **MATP**.
AFDC	Members qualifying for Money Grant plus Medicaid under the AFDC program. The following aid categories comprise **AFDC** for this report: **MA C**, **MA F**, **MA H**, **MA O**, **MA Q**, **MA S**, **MA T**, **MA U**, **MA 4**, **MA 8**, **MACP**, **MAFP**, **MAOP**, **MASP**, **MATP**, **MAUP**, **MA4P**, and **MA8P**.
Medicaid For Preg Women	Members qualifying for Money Grant plus Medicaid under the Medicaid for Pregnant Women program. The following aid categories comprise Medicaid For Pregnant Women for this report: **MA E**, **MA M**, **MA N**, **MA P**, **MAMP**, **MANP**, and **MAPP**.
Medicaid For Children	Members qualifying for Money Grant plus Medicaid under the Medicaid for Children program. The following aid categories comprise Medicaid For Children for this report: **MA Y**, **MA Z**, **MA 1**, **MA 2**, **MA 3**, **MAYP**, **MAZP**, **MA1P**, **MA2P**, and **MA3P**.
Medicaid For Newborn	Members qualifying for Money Grant plus Medicaid under Medicaid for Newborn program. The following aid categories comprise Medicaid For Newborns for this report: **MA X** and **MAXP.**
Money Grant Total	The combined total of the columns as follows: Aged, Blind, Disabled, AFDC, Medicaid For Pregnant Women, Medicaid For Children, and Medicaid For Newborns.

Each of the above categories is divided into Normal Billing, Verified Accretions, Verified Deletions, and Balance depending on the reported transaction codes.

Normal Billing	Includes all 41bb transaction codes from the Billing Part B tape for each Money Grant category. The 41bb (41__) is an ongoing Buy In Part B member. CMS has already bought in this member and continues to bill IFSSA for each month's premium. Refer to the Buy In manual for the transaction codes.
Verified Accretions	This includes all 11XX and 43XX transaction codes. The code 11XX means CMS has accepted the accretion attempt for this recipient for the effective date requested. An 1167 means CMS is reporting to IFSSA that this recipient has accreted for that effective date. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy-In manual for the transaction codes.
Verified Deletions	This includes all 15bb (15__), 16bb (16__), 17XX, 42XX, and 42bb (42__) transaction codes. This code means CMS is stopping a recipient's Buy In coverage. This code are a credit to IFSSA or CMS is sending a credit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Balance	A balance is given for the total of the **Normal Billing** plus the **Verified accretions**, minus the **Verified Deletions** for each of the Money Grant categories.
Non Money Grant	Category reflects a member who is in an IHCP but not receiving any part of the following: SSI, AFDC, RBA, or State Supplemental Assistance. The member may receive other income so long as none of the income is derived from the above sources. To identify **Non-Money Grant** members, the system searches the billing record for an eligibility code of **M** in position 50. These members are not eligible for the following programs: SSI (Social Security), AFDC (Aid for Families with Dependent Children), RBA (Room and Board Administration), or State Supplement Assistance. Members without dual eligibility are included in the columns for **Non-Money Grant**; all others are included in the columns for **Money Grant**.
Category Header	Aid categories under the Medicare Part B Buy In Non Money Grant program. The following are the category headers: **Aged**, **Blind**, **Disabled**, **AFDC**, **Medicaid For Pregnant Women**, **Medicaid For Children**, **Medicaid For Newborns**, **Non Money Grant Total**
Aged	Members qualifying for Non Money Grant plus IHCP under the Aged program. The following aid categories comprise **Aged** for this report: **MA A**, **MA 5**, **MAAP**, and **MA5P**.
Blind	Members qualifying for Non Money Grant plus IHCP under the Blind program. The following aid categories comprise **Blind** for this report: **MA B**, **MA 6**, **MABP**, and **MA6P**.
Disabled	Members qualifying for Non Money Grant plus IHCP under the Disabled program. The following aid categories comprise **Disabled** for this report: **MA D**, **MA R**, **MA 7**, **MADP**, **MAGP**, **MARP**, and **MATP**.
AFDC	Members qualifying for Non Money Grant plus IHCPunder the AFDC program. The following aid categories comprise **AFDC** for this report: **MA C**, **MA F**, **MA H**, **MA O**, **MA Q**, **MA S**, **MA T**, **MA U**, **MA 4**, **MA 8**, **MACP**, **MAFP**, **MAOP**, **MASP**, **MATP**, **MAUP**, **MA4P**, and **MA8P**.
Medicaid For Preg Women	Members qualifying for Non Money Grant plus IHCP under the Medicaid for Pregnant Women program. The follow aid categories comprise **Medicaid For Pregnant Women** for this report: **MA E**, **MA M**, **MA N**, **MA P**, **MAMP**, **MANP**, and **MAPP**.

Medicaid For Children	Members qualifying for Non Money Grant plus IHCP under the Medicaid for Children program. The following aid categories comprise **Medicaid For Children** for this report: **MA Y**, **MA Z**, **MA 1**, **MA 2**, **MA 3**, **MAYP**, **MAZP**, **MA1P**, **MA2P**, and **MA3P**.
Medicaid For Newborn	Recipients qualifying for Non Money Grant plus IHCP under the Medicaid for Newborn program. The following aid categories comprise **Medicaid For Newborn** for this report: **MA X** and **MAXP**.
Non Money Grant Total	The combined total of the columns as follows: Aged, Blind, Disabled, AFDC, Medicaid For Pregnant Women, Medicaid For Children, and Medicaid For Newborns.

Each of the above categories are divided into Normal Billing, Verified Accretions, Verified Deletions, and Balance depending on the reported transaction codes.

Normal Billing	Includes all 41bb transaction codes from the Billing Part B Tape for each Non Money Grant category. The 41bb (41__) is an ongoing Buy In Part B member. CMS has already bought in this member and continues to bill IFSSA for each month's premium. Refer to the Buy In manual for the transaction codes
Verified Accretions	This includes all 11XX and 43XX transaction codes. The code 11XX means CMS has accepted the accretion attempt for this member for the effective date requested. An 1167 means CMS is reporting to IFSSA that this member has been accreted for that effective date. The 43XX means CMS sent a debit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Verified Deletions	Includes all 15bb (15__), 16bb (16__), 17XX, 42XX, and 42bb (42__) transaction codes. These codes mean CMS is stopping a member's Buy In coverage. These codes are a credit to IFSSA or CMS is sending a credit adjustment of premium liability. Refer to the Buy In manual for the transaction codes.
Balance	Given for the total of the **Normal Billing** plus the Verified Accretions, minus the Verified Deletions for each of the Non Money Grant categories.
Premium Totals	Category reflecting the listing of the Premiums Billed By Category, divided into the following Buy In Part B programs: **Money Grant**, **Non Money Grant**, **QMB Also**, **QMB Only**, **SLMB Also**, **SLMB Only**, **Unknown**, and **Combined Total**.
Category Header	The individual categories for which premiums are paid. They include **Money Grant**, **Non Money Grant**, **QMB Also**, **QMB Only**, **SLMB Also**, **SLMB Only**, **Unknown**, and **Combined Total**.
Money Grant	Total premiums for members in IHCP who are receiving money from one of the following: SSI, AFDC, RBA, or State Supplemental Assistance. This total is from the **Money Grant Total** column under the **Premiums Billed by Category**.
Non Money Grant	Total premiums for members are on Medicaid who are not receiving any money from SSI, AFDC, RBA or State Supplemental Assistance. This total is from the **Non Money Grant Total** column under the **Premiums Billed by Category.**
QMB Also	Total premiums for Qualified Medicare Beneficiaries who are also eligible for other programs in IHCP. This total is from the **QMB Also Total** column under the **Premiums Billed by Category.**

QMB Only	Total premiums for Qualified Medicare Beneficiaries who are not eligible for other programs in IHCP. This total is from the **QMB Only** column under the **Premiums Billed by**
SLMB Also	Total premiums for Specified Low Income Medicare Beneficiaries who also qualify for other programs in IHCP. This total is from the **SLMB Also Total** column under the Premiums Billed by Category.
SLMB Only	Total premiums for Specified Low Income Medicare Beneficiaries who do not qualify for any other programs in IHCP. This total is from the **SLMB Only** column under the **Premiums Billed by Category**.
QI Only	Premiums for Qualified Individuals who do not qualify for any other programs in IHCP. This total is from the **QI Only** column under the **Premiums Billed by Category**.
Unknown	Total premiums for all members on the Billing tape that do not have a RID number, or who do not a match with an entry in the Eligibility window, or whose Billing record is on the exception error report.
Combined Total	A total of all the above categories; **Money Grant. Non Money Grant**, **QMB Also**, **QMB Only**, **SLMB Also**, **SLMB Only**, and **Unknown**, from the Billing Tape

Each of the above categories are divided into Normal Billing, Verified Accretions, Verified Deletions, and Balance depending on the reported transaction codes.

Normal Billing	Totals from Normal Billing for each of the following programs: Money Grant, Non Money Grant, QMB Also, QMB Only, SLMB Also, SLMB Only, Unknown, and Combined Total.
Verified Accretions	Totals from Verified Accretions for each of the following programs: Money Grant, Non Money Grant, QMB Also, QMB Only, SLMB Also, SLMB Only, Unknown, and Combined Total.
Verified Deletions	Totals from Verified Deletions for each of the following programs: Money Grant, Non Money Grant, QMB Also, QMB Only, SLMB Also, SLMB Only, QI Only, Unknown, and Combined Total
Balance	Balance of the totals of Normal Billing plus the Verified Accretions minus the Verified Deletions for each of the following: Money Grant, Non-Money Grant, QMB Also, QMB Only, SLMB Also, SLMB Only, QI Only, Unknown, and Combined Total.
Category Header	Amount IFSSA may or may not be reimbursed for each member who is on Buy n Part B for the current month, including FFP, Non FFP, and Total. The next headers are cumulative totals to date for **Federal FY**, **State FY,** and **Calendar Year**
FFP	The Federal Financial Participation (FFP) is paid by CMS for members eligible for QMB, SLMB or Money Grant, and for whom IFSSA is paying Medicare premiums
Non FFP	The Federal government does not pay IFSSA for members who are Non-Money Grant. The **Unknown** category is also included in this calculation

Total	Total of the **FFP** and **Non FFP** columns.
Fed FY	Federal Fiscal Year begins October 1 and ends September 30. The Federal government uses this period for annual calculations. Fed FY is a year to date total for the credits and debits lines. Because there is not a number or amount for the current or retro months, the total is not from adding the column but rather from the FFP, plus the Non FFP Total, plus the year to date.
State FY	State Fiscal Year begins July 1 and ends June 30. The state government uses this period for annual calculations. This is a year–to date total for the credits and debits lines. Because there is not a number or amount for the current or retro months, the total is not from adding the column but rather from the FFP, plus the Non FFP Total, plus the year to date.
Calendar Year	Begins January 1, and ends December 31. This is a year to date for the credits and debits lines. However, because there is not a number or amount for the current or retro months the total is not from adding the column but rather from the FFP, plus the Non FFP Total, plus the year–to date.

The following items are included in the calculation of the number of months and amount of premiums billed on the current months billing tape and the accumulation of the different annual calculations:

- Number of current month's premiums being billed
- Number of retro months' premiums being billed
- Number of months credit was received
- Number of months debit was received
- Total number of months' premiums being billed
- Dollar amount of current month's premiums being billed
- Dollar amount of retro active month's premiums being billed
- Dollar amount of months credit was received
- Dollar amount of months debit was received
- Total dollar amount of months' premiums being billed

Number Of Current Month's Premiums Being Billed	This is the number of transactions on the Billing Tape that have a code 41bb (41__). All of these transaction codes have only the current month's effective date. The 11XX have one month premiums (as the current month) and may also have retro months premiums billed. If the effective date of the 11XX is less than the current month, one is the current month and the remaining months are added to the retro months. Therefore, by checking the effective date of the transaction code the system determines the number of retro months to add, with the exception of codes 1172 and 1175. These codes are not for the current month's premiums unless the 1772 or 1776 effective date shows the current month as the effective date. Refer to the Number of Retro Months' Premium being Billed for details. There is not a number for Federal, State, or Calendar Fiscal Year.
Number Of Retro Months Premiums Being Billed	The number of retroactive months for which CMS is billing IFSSA on the current month's Billing Tape. To determine this number, the system identifies members with transaction codes of 11XX, and 17XX. Then the system looks at the effective date of each 11XX and 17XX transaction code. If the effective date is equal to the

current billing month, it is added to the current month premium billed. If the effective date is less than the current billing month, one month is the current month and the rest of the months count as retro months' premiums billed. The same procedures applies to the two transaction code pairs 1172/1772 and 1175/1776, if the 1772 or 1776 effective dates are equal to the current billing month (*example:* the current month 7/94, current date 6/94), one month is for the current month and the rest are retro months. ***Example***: If the Billing tape has an 1161 transaction code with an effective date of 1/94, and the current month is 7/94, one month is put with the current month and the other 6 months are retro months. If an 1175 code has an effective date of 1/94, the 1776 code has an effective date of 5/94, and the current month is 7/94, all five months will be retro months. There is not a number for Federal Fiscal Year, State Fiscal Year, or Calendar Fiscal Year.

Number Of Months Credit Was Received

The number of months for which a credit was received by the OMPP. This is all of the42bb and 42XX transaction codes. The transaction code with or without an effective date has the following system action: the current year monthly premium amount (1/94 – 12/94 the premium is $41.10 per month per member) is divided by the total amount of premium billed. The number of times the monthly premium goes into the total premium is the number for that transaction code. If the number does not come out even it is rounded down. There is an annual calculated number for the Federal Fiscal Year, the State Fiscal Year, and Calendar Fiscal Year.

Number Of Months Debit Was Received

The number of months for which a debit was received by the OMPP. This is all the 43XX transaction codes. The transaction code with or without an effective date has the following system action: the current year monthly premium amount (1/94 - 12/94 the premium is $41.10 per month per recipient) is divided by the total amount of premium billed. The number of times the monthly premium goes into the total premium is the number for that transaction code. If the number does not come out even, it is rounded down. There is an annual calculated number for Federal Fiscal Year, State Fiscal Year, and Calendar Fiscal Year.

Total Number Of Months Premium Being Billed

The Number of Current Month Premiums Being Billed plus the Number of Retro Months' Premiums Being Billed, plus the Number of Months Credit Was Received, minus the Number of Months Debit Was received, equals the Total Number of Months' Premiums Billed.

Dollar Amount Of Current Month's Premiums Being Billed

The dollar amount of transactions on the Billing Tape that have a code 41bb (41__). All of these only have the current month's effective date. The 11XX has one month's premiums (as the current month), and may also have retro months premiums billed. If the effective date (current billing month) of the 11XX is less than the current month, one is the current month and the remaining months are added to the retro months. Therefore, by checking the effective date of the transaction code the system determines the amount of retro months to add. With the exception of codes 1172 and 1175, additions are not for current months premiums unless the 1772 or 1776 effective date shows the current month as the effective date. (See Dollar Amount of Retro Month Premiums being Billed for details.) There is not a dollar amount for Federal Fiscal Year, State Fiscal Year, or Calendar Fiscal Year.

Dollar Amount Of Retro Month Premiums Being Billed

The dollar amount for retroactive months for which CMS is billing IFSSA on the current month's Billing Tape. To determine this number, the system identifies members with transaction codes of 11XX, and 17XX. The system looks at the effective date of each 11XX and 17XX transaction code. If the effective date is equal to the current billing month, it is added to the current month premium being billed. If the effective date is less than the current month, one month is the current

	month and the rest of the month counts as retro months premiums billed. The same procedure applies to the two transaction code pairs 1172/1772 and 1175/1776. If the 1772 or 1776 effective date equals the current billing month, one month premium is for the current month and the rest of the premium amount is retro months. **Example**: if the Billing tape has an 1161 transaction code with an effective date of 1/94, and the current month is 7/94, one month premium amount is put with the current month and the other six months premiums retro months.. If an 1175 code has an effective date of 1/94 and the 1776 code has an effective date of 5/94, and the current date is 7/94, all five months will be retro months. There is not a dollar amount for Federal Fiscal Year, State Fiscal Year, or Calendar Fiscal Year.
Dollar Amount Of Month's Credited Was Received	The dollar amount for which a credit was received by the OMPP. This includes all the 42bb and 42XX transaction codes. The whole dollar amount, with or without an effective date, is added to this column. There is an annual calculated dollar amount for Federal, and State Fiscal Year, and Calendar Fiscal Year.
Dollar Amount Of Month's Debited Was Received	The dollar amount for which a debit was received by the OMPP. This is all the 43XX transaction codes. The whole dollar amount, with or without an effective date, is added to this column. There is an annual calculated dollar amount for Federal Fiscal Year, and State Fiscal Year, and Calendar Fiscal Year.
Total Dollar Amt. Of Month Premiums Being Billed	The total from Dollar Amount of Current Month Premiums Being Billed columns, plus the Dollar Amount of Retro Month Premiums Being Billed, plus the Dollar Amount of Months Credited Was Received, minus the Dollar Amount of Months Debited Was Received equals the Total Dollar Amount of Months Premiums Billed.
Records Received From HCFA	Is an itemization on the Buy In Part B Billing Tape records by **Accretions**, transaction codes (11XX, 41bb, and 43XX), **Deletions** transaction codes (15bb (15__), 16bb (16__), 17XX, 42XX, and 42bb), and **Informational** transaction codes (20XX, 21XX, 22XX, 23bb, 23XX, 24XX, 25XX, 27XX, 28XX, 29XX, 30XX, 31XX, 32XX, 33XX, 49XX, 86bb, and 87bb), and the TOTAL of all transaction codes.
Accretions	The number of 41bb, 11XX, and 43XX transaction codes received on the Medicare Part B Buy In Billing Tape. Refer to the Buy In manual for the transaction codes.
Deletions	The number of 15bb (15__), 16bb (16__), 17XX, 42XX, and 42bb transaction codes received on the Medicare Part B Buy In Billing Tape. Refer to the Buy In manual for the transaction
Informational	The number of transaction codes used by CMS to inform the State of various informational changes or monitoring codes. The informational codes are as follows: 20XX, 21XX, 22XX, 23bb, 24XX, 25XX, 27XX, 28XX, 29XX, 30XX, 31XX, 32XX, 33XX, 49XX, 86bb, and 87XX. Refer to the Buy In manual for transaction codes).
Total Records Sent To HCFA	The total of all the Accretions, Deletions, and Informational lines from the above Medicare Part B Buy- In Billing Tape. An itemization of records on the Premium 150 Tape going to HCFA from EDS/FSSA.
Accretions	The number of 61, 62, 63, 75, and 84 transaction codes on the Premium 150 Tape going to CMS from EDS/FSSA.
Deletions	The number of 50, 51, 53, and 76 transaction codes on the Premium 150 Tape going to CMS from EDS/FSSA.

Informational	The number of 99 transaction codes on the Premium 150 Tape going to CMS from EDS/FSSA.
Total	The total of all records on the Premium 150 Tape going to CMS from EDS/FSSA.

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PREMIUMS BILLED BY CATEGORY

QMB ALSO

CATEGORY HEADER	QMB/AGED +	QMB/BLIND +	QMB/DISABLED +	QMB/AFDC =	QMB ALSO TOTAL
NORMAL BILLING	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED DELETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
BALANCE	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999

SLMB ALSO

CATEGORY HEADER	SLMB/AGED +	SLMB/BLIND +	SLMB/DISABLED +	SLMB/AFDC =	SLMB ALSO TOTAL
NORMAL BILLING	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED DELETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999
BALANCE	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999

QMB/SLMB ONLY

CATEGORY HEADER	QMB ONLY	SLMB ONLY
NORMAL BILLING	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999
VERIFIED DELETIONS	99,999,999	99,999,999
BALANCE	99,999,999	99,999,999

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MONEY GRANT

CATEGORY HEADER	AGED +	BLIND +	DISABLED +	AFDC +	MEDICAID PREG WOMEN +	MEDICAID CHILDREN +	MEDICAID NEWBORN =	MONEY GRANT TOTAL
NORMAL BILLING	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED DELETIONS	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999
BALANCE	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999

NON-MONEY GRANT

CATEGORY HEADER	AGED +	BLIND +	DISABLED +	AFDC +	MEDICAID PREG WOMEN +	MEDICAID CHILDREN +	MEDICAID NEWBORN =	NON MONEY GRANT TOTAL
NORMAL BILLING	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED ACCRETIONS	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999
VERIFIED DELETIONS	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999
BALANCE	99,999	99,999,999	99,999,999	9,999,999	99,999,999	99,999,999	99,999,999	99,999,999

PREMIUM TOTALS

CATEGORY HEADER	MONEY GRANT +	NON-MONEY GRANT+	QMB ALSO +	QMB ONLY +	SLMB ALSO +	SLMB ONLY +	UNKNOWN =	COMBINED TOTAL
NORMAL BILLING	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	9,999,999
VERIFIED ACCRETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	9,999,999
VERIFIED DELETIONS	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	9,999,999
BALANCE	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	99,999,999	9,999,999

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CATEGORY HEADER	FFP	NON FFP	TOTAL	FED FY (Year to date)	STATE FY (Year to date)	CALENDAR YEAR (Year to date)
NUMBER OF CURRENT MONTH'S PREMS BEING BILLED	99,999	99,999	999,999	N/A	N/A	N/A
NUMBER OF RETRO MONTH'S PREMS BEING BILLED	99,999	99,999	999,999	N/A	N/A	N/A
NUMBER OF MONTH'S CREDITED WAS RECEIVED	99,999	99,999	99,999	99,999	99,999	99,999
NUMBER OF MONTH'S DEBITED WAS RECEIVED	99,999	99,999	99,999	99,999	99,999	99,999
TOTAL NUMBER OF MONTH'S PREMIUMS BEING BILLED	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999	9,999,999
DOLLAR AMOUNT OF CURRENT MONTH'S PREMS BEING BILLED	$99,999,999.99	999,999,999.99	999,999,999.99	N/A	N/A	N/A
DOLLAR AMOUNT OF RETRO MONTH'S PREMS BEING BILLED	$999,999,999.99	999,999,999.99	999,999,999.99	N/A	N/A	N/A
DOLLOR AMOUNT OF MONTH'S CREDITED WAS RECEIVED	999,999,999.99	999,999,999.99	999,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
DOLLOR AMOUNT OF MONTH'S DEBITED WAS RECEIVED	999,999,999.99	999,999,999.99	999,999,999.99	9,999,999.99	9,999,999.99	9,999,999.99
TOTAL DOLLOR AMOUNT OF PREMIUMS BEING BILLED	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99	999,999,999.99

RECORDS RECEIVED FROM HCFA
RECORD SENT TO HCFA

ACCRETIONS:	99,999,999	**ACCRETIONS:** 99,999,999
DELETIONS:	99,999,999	**DELETIONS:** 99,999,999
INFORMATIONAL:	99,999,999	**INFORMATIONAL:** 99,999,999
TOTAL:	999,999,999	**TOTAL**: 99,999,999

** END OF REPORT **

** NO DATA THIS RUN **

Section 6: BUY Reports

BUY-3001-M Possible Medicare Eligibles

Functional Area	Report Number	Job Name	Report Title
Buy-In	BUY-3001-M		Possible Medicare Eligibles

Description of Information

The Possible Medicare Eligibles report reads the recipient paid crossover claim files. If a recipient has a crossover claim that paid, the Medicare table in eligibility is checked to see if the recipient has Medicare A or Medicare B. The recipients who do not have Medicare A or B show up on the Possible Medicare Eligibles report.

Purpose

The purpose of the Possible Medicare Eligibles report is to identify those individuals who had crossover claims paid by Medicare, but do not show Medicare A or B in the recipient data base.

Sort Sequence

- *Primary -* SSN, ascending order with left justification.

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

SSN	Recipient's Social Security Number in the recipient paid Medicare table in the recipient paid claims file
Last	Recipient's last name on the recipient Medicare table in the recipient paid claims file
First	Recipient's first name in the recipient paid Medicare table in the recipient paid claims file
MI	Recipient's middle initial in the recipient paid Medicare table in the recipient paid claims file
HIB	Recipient's Medicare number in the recipient paid Medicare table in the recipient paid claims file
Birth	Recipient's date of birth (CCYYMMDD format) in the recipient paid Medicare table in the recipient paid claims file
RID	Recipient's 12-character numeric identification number in the recipient paid Medicare table in the recipient paid claims file

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Report:  BUY-3001-M                       IndianaAIM                          Run Date:  MM/DD/CCYY
Process:                                                                      Run Time:  HH:MM
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                              Period:  MM/DD/CCYY through MM/DD/CCYY


    SSN           LAST             FIRST          MI          HIB          BIRTH        RID

 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx
 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx
 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx
 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx
 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx
 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx
 XXXXXXXXX    XXXXXXXXXXXX        XXXXXXX         X       XXXXXXXXXXXX    MMDDYY    xxxxxxxxxxxx



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BUY-3002-W ICES Medicare and HIB Update Errors

Functional Area	Report Number	Job Name	Report Title
Buy-In	BUY-3002-W		ICES Medicare and HIB Update Errors

Description of Information

The Attempted HIB Updates To Already Accreted Buy-In Recipient report indicates all ongoing Buy-In Part A or B recipients for whom ICES sent an HIB update to Indiana*AIM* since the last Buy-In cycle. There are three exceptions:

If the recipient's marital status changed from aged married to aged Widow (the HIB number would go from B to D).

If a disabled widow **W** (age 50-59) changes to aged widow **D** (age 60).

If a spouse of a RR employee or annuitant **MA** (husband or wife) became a widower or widow, the HIB number would change from **MA** to **WA** (annuitant) or **WD** (RR employee)

Purpose

The purpose of this report is to identify the recipients for whom ICES is trying to change HIB numbers in Indiana*AIM*. There may be other valid HIB number changes, but most are verified before sending to CMS.

Sort Sequence

- *Primary* - County number, ascending
- *Secondary* - HIB number, ascending

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly
IFSSA	CRLD/Paper	1	Weekly

Detailed Field Definitions

HIB	Current Medicare identification number for that recipient from the recipient Medicare table
New HIB	The HIB number that ICES sent after recipient already accreted to Buy-In
Caseworker	A six-character numeric code that identifies the number of the caseworker assigned to this recipient
RID	Recipient's 12-character numeric identification number from the Recipient base table
Last	Recipient's last name from the current recipient base table
First	Recipient's first name from the current recipient base table
MI	Recipient's middle initial from the current recipient base table

```
Report:  BUY-3002-W                                        IndianaAIM                                      Run Date:  MM/DD/CCYY
Process:                                                                                                        Run Time:  HH:MM
Location:                                          ATTEMPTED HIB UPDATES TO                                   Page:      99,999
                                                            ALREADY ACCRETED BUY-IN

                                                                  COUNTY: XX

                         HIB            NEW HIB          CASEWORKER            RID                LAST                 FIRST           MI

                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X
                     XXXXXXXXXXXX      XXXXXXXXXXXX         XXXXXX          XXXXXXXXXXXX       XXXXXXXXXXXX            XXXXXXX           X

                                                             * * END OF REPORT * *

                                                           * * NO DATA THIS RUN * *
```

BUY-3003-D Buy-In Linked Recipients

Functional Area	Report Number	Job Name	Report Title
Buy-In	BUY-3003-D	BUY-3003	Buy-In Linked Recipients

Description of Information

This report lists all recipients included in a linking or unlinking transaction as part of the daily interface with ICES and Buy-In data appears under one or both RID numbers in Indiana*AIM*. The report includes the data on the inactive RID number as well as the data on the active RID number.

To identify recipients with Buy-In, the system checks the Buy-In Part A and Part B billing data, looks for the buy-in process date, and selects the records that show a process date equal to the current month or the previous month. (These tables are "TRE_BUYA_BILL" and "TRE_BUYB_BILL")

Purpose

The purpose of this report is to identify recipients who ICES linked or unlinked and the have two RID numbers with Medicare Buy-In data attached. This report is researched and manual data entry is performed to ensure that the necessary changes and accretions or deletions are coordinated with CMS via the monthly Premium jobs.

Sort Sequence

- *Primary* - Linking transactions: new RID number.
- *Secondary* - Unlinking transactions: newly activated RID

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Daily
FSSA	CRLD/Paper	1	Daily

Detailed Field Definitions

RID	Recipient's 12-character numeric identification number from the Recipient base table (current and prior)
HIB	Medicare identification number for the newly activated recipient from the recipient Medicare table
Last	Recipient's last name from the recipient base table
First	Recipient's first name from the recipient base table
MI	Recipient's middle initial from the recipient base table
Caseworker	A six-character alphanumeric field that identifies the caseworker assigned to this recipient from the recipient base table

Report: BUY-3003-DIndiana*AIM*Run Date: MM/DD/CCYY
Process:Run Time: HH:MM
Location:BUY-IN LINKED RECIPIENTSPage: 99,999

OLD RID NUMBER NEW RID NUMBER	HIB	LAST NAME	FIRST NAME	M.I.	CASEWORKER
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	X	XXXXXX
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX y	X	XXXXXX
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	X	XXXXXX
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	X	XXXXXX

BUY-IN UNLINKED RECIPIENTS

OLD RID NUMBER NEW RID NUMBER	HIB	LAST NAME	FIRST NAME	M.I.	CASEWORKER
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	X	XXXXXX
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX y	X	XXXXXX
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	X	XXXXXX
XXXXXXXXXXXX XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXX	X	XXXXXX

* * END OF REPORT * *

* * NO DATA THIS RUN * *

Section 7: CLM Reports

CLM-0100-M Claim Count by Claim Type

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0100-M	CLMJM100M	Claim Count by Claim Type

Description of Information

The report shows the number of claims received by EDS for the month reported. This report is sorted by claim type and media type.

Purpose

The claim count report is used by EDS and IFSSA to evaluate the number of claims received by media type for each claim type.

Sort Sequence

- *Primary* - Claim type
- *Secondary* - Media type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

Claim Type

The type of claim form received by EDS. Valid values:

- Inpatient
- Outpatient
- Long term care
- Pharmacy
- CMS-1500
- Dental
- Home health
- Inst xover
- Outp xover
- CMS xover
- Compound drug

No. Of Computer Generated Claims

The number of claims received by EDS that were computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **1** (typed or computer generated)

No. Of Handwritten Claims	The number of claims received by EDS that were not computer printed, determined by the EC indicator on the Viking screen. This shows the total claims with indicator of **0** (handwritten)
Total Paper Claims	The number of computer-generated claims plus the number of handwritten claims
% Computer Generated	The number of computer-generated claims divided by total paper claims multiplied by 100
No. ECS Claims	The number of claims received by EDS that were submitted via computer disk, tape, cartridge, or telecommunication. This shows the total claims with region code 20
% ECS OF Total ECC	The number of ECS claims divided by the total number of ECC claims multiplied by 100
No. POS Claims	The number of claims received by EDS submitted via Point of service (POS). This shows the total claims with region code 25
% POS OF Total ECC	The number of POS claims divided by the total number of ECC claims multiplied by 100
Total ECC	The number of ECS claims plus the number of POS claims
Total Claims	Total paper claims plus total ECC

REPORT: CLM-0100-M
PROCESS:
LOCATION:

IndianaAIM
CLAIM COUNT --Claim Type
Period: MM/DD/YY - MM/DD/YY

DATE: CCYYMMDD
RUN TIME: HH:MM:SS
PAGE: 99,999

CLAIM TYPE	NO. COMPUTER GENERATED CLAIMS	NO. HANDWRITTEN CLAIMS	% COMPUTER GENERATED	TOTAL PAPER CLAIMS	NO. ECS BATCH CLAIMS	NO. POS CLAIMS	% POS	TOTAL ECS	% ECS OF TOTAL	TOTAL CLAIMS
INPATIENT	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
OUTPATIENT	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
LONG TERM CARE	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
PHARMACY	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
HCFA 1500	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
DENTAL	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
HOME HEALTH	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
TOTAL	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999

END OF REPORT

CLM-0105-M Claim Count—Provider Type

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0105-M	CLMJM105	Claim Count—Provider Type

Description of Information

The report shows the number of claims received by EDS for the month reported. This report is sorted by provider type and media type.

Purpose

The Claim Count report is used by EDS and IFSSA to evaluate the number of claims received by media type for each provider type.

Sort Sequence

- *Primary* - Provider type
- *Secondary* - Media type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

Provider Type	The two-byte numeric field that represents the type of service rendered by the rendering provider. The provider type description is printed next to the two-byte provider type field.
No. Of Computer Generated Claims	The number of claims received by EDS that were computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **1** (typed or computer generated)
No. Of Handwritten Claims	The number of claims received by EDS that were not computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **0** (handwritten)
Total Paper Claims	The number of computer-generated claims plus the number of manual claims
% Computer Generated	The number of computer-generated claims, divided by the total number of paper claims, multiplied by 100
No. ECS Claims	The number of claims received by EDS submitted via computer disk, tape, cartridge, or telecommunication. This shows the total claims with region code 20 or 21

% ECS Of Total	The number of ECS claims, divided by the total number of ECC claims, multiplied by 100
No. POS Claims	The number of claims received by EDS submitted via point of service (POS). This shows the total claims with region code 25
% POS	The number of POS claims, divided by the total number of ECC claims, multiplied by 100
Total ECC	The number of ECS claims plus the number of POS claims
Total Claims	Total paper claims plus total ECC

```
REPORT: CLM-0105-M                         IndianaAIM                                      DATE: CCYYMMDD
PROCESS:                           CLAIM COUNT --Provider Type                           RUN TIME: HH:MM:SS
LOCATION:                        Period: MM/DD/YY - MM/DD/YY                                PAGE: 99,999


                            NO. COMPUTER                          %        TOTAL    NO. ECS
                             GENERATED    NO. HANDWRITTEN     COMPUTER     PAPER     BATCH    NO. POS              TOTAL    % ECS OF     TOTAL
PROVIDER TYPE                  CLAIMS         CLAIMS          GENERATED    CLAIMS    CLAIMS    CLAIMS     % POS      ECS       TOTAL      CLAIMS

99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999
99 - XXXXXXXXXXXXXXXXXX       9999999        9999999           9999999    9999999   9999999   9999999   9999999   9999999   9999999    9999999

TOTAL                        99999999       99999999          99999999   99999999  99999999  99999999  99999999  99999999  99999999   99999999

                                                       END OF REPORT
```

CLM-0109-W Remittance Advice

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0109-W		Remittance Advice

***This report is currently in SME review. 12/27/00*

CLM-0110-M Claim Count—Individual Provider

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0110-M	CLMJM110	Claim Count—Individual Provider

Description of Information

The report shows the number of claims received by EDS for the month reported. This report is sorted by individual provider number and media type.

Purpose

The Claim Count report is used by EDS and IFSSA to evaluate the number of claims received by media type for each individual provider.

Sort Sequence

- *Primary* - Provider number
- *Secondary* - Media type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

Individual Provider No.	The provider number of the rendering provider
No. Of Computer Generated Claims	The number of claims received by EDS that were computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **1** (typed or computer generated)
No. Of Handwritten Claims	The number of claims received by EDS that were not computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **0** (handwritten)
Total Paper Claims	The number of computer-generated claims plus the number of manual claims
% Computer Generated	The number of computer-generated claims divided by the total number of paper claims multiplied by 100
No. ECS Claims	The number of claims received by EDS submitted via computer disk, tape, cartridge, or telecommunication. This shows the total claims with region code 20 or 21.
% ECS Of Total	The number of ECS claims, divided by the total number of ECC claims, multiplied by 100.

No. POS Claims	The number of claims received by EDS submitted via Point of service (POS). This shows the total claims with region code 25.
% POS	The number of POS claims, divided by the total number of ECC claims, multiplied by 100
Total ECC	The number of ECS claims plus the number of POS claims
Total Claims	Total paper claims plus total ECC

REPORT: CLM-0110-M	**IndianaAIM**	DATE: CCYYMMDD
PROCESS:	**CLAIM COUNT --Individual Provider**	PAGE: 99,999
LOCATION:	**Period: CCYY/MM/DD - CCYY/MM/DD**	

PROVIDER NO.	NO. COMPUTER GENERATED CLAIMS	NO. HANDWRITTEN CLAIMS	% COMPUTER GENERATED	TOTAL PAPER CLAIMS	NO. ECS BATCH CLAIMS	NO. POS CLAIMS	% POS	TOTAL ECS	% ECS OF TOTAL	TOTAL CLAIMS
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
999999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
TOTAL	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999

END OF REPORT

CLM-0112-M Wrong LTC Revenue Code at Half Rate

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0112-M	CLMJM112	Wrong LTC Revenue Code at Half Rate

Description of Information

The Wrong LTC Revenue Code at Half Rate Report displays claim information when a provider bills for a 50%-rate leave day using a full-rate revenue code.

Purpose

Long Term Care claims are currently paid using Case Mix, which provides the potential for a claim's allowed (paid) amount to be greater than the billed amount. The Wrong LTC Revenue Code at Half Rate Report may be used by the Long Term Care unit to identify and adjust a claim that was coded with the wrong revenue code for a 50%-rate leave day.

Sort Sequence

- *Primary* - Provider ID
- *Secondary* - ICN

Distribution

To	Media	Copies	Frequency
EDS	E-mail	0	Monthly
OMPP	E-mail	0	Monthly

Detailed Field Definitions

Provider ID	Billing provider's Indiana*AIM* identification number
Provider Name	If the billing provider is a person's name, it is listed as "Last, First M". Otherwise, the name is displayed as it is stored in the database.
ICN	Identifies the claim control number
Recipient:ID	Recipient's Indiana*AIM* identification number
Recipient:Name	Recipient's first and last name
From	First date of service of the claim
To	Last date of service of the claim
Rev	Revenue code of the claim detail
Billed	Amount billed by the provider
Allowed	Amount allowed (paid) by the system.

```
Report  : CLM-0112-R                    IndianaAIM                    Run Date: 05/25/2001
Process : CLMJM112            Wrong LTC Revenue Code @ 1/2 Rate       Run Time: 08:54:28
Location: CLMPM112

Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99


Provider ID : 999999999   Provider Name : xxxxxxxxxxxxxxxxxxxxxx
     ICN      Recipient:ID          Name             From      To    Rev  Billed   Allowed
------------- ------------ ----------------------- -------- -------- --- -------- --------
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99
9999999999999 999999999999 xxxxxxxxxxxxxxxxxxxxxxx ccyymmdd ccyymmdd 110   999.99   9999.99
```

CLM-0115-M Claim Count by Geographical Area

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0115-M	CLMJM115	Claim Count by Geographical Area

Description of Information

The report shows the number of claims received by EDS for the month reported. This report is sorted by geographical area and media type.

Purpose

The Claim Count report is used by EDS and IFSSA to evaluate the number of claims received by media type for each geographical area.

Sort Sequence

- *Primary* - Geographical area
- *Secondary* - Media type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Monthly
IFSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

Geographical Area	The geographical area where the service was rendered. Geographical area is based on the two-byte alphanumeric county code carried in the provider file. The county name appears next to its two-byte county code.
No. Of Computer Generated Claims	The number of claims received by EDS that were computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **1** (typed or computer generated).
No. Of Handwritten Claims	The number of claims received by EDS that were not computer printed. This is determined by the EC indicator on the Viking screen. This only shows the total claims with indicator of **0** (handwritten).
Total Paper Claims	The number of computer-generated claims plus the number of manual claims
% Computer Generated	The number of computer-generated claims, divided by the total number of paper claims, multiplied by 100

No. ECS Claims	The number of claims received by EDS submitted via computer disk, tape, cartridge, or telecommunication. This shows the total claims with region code 20 or 21.
% ECS Of Total	The number of ECS claims, divided by the total number of ECC claims, multiplied by 100
No. POS Claims	The number of claims received by EDS submitted via point of service (POS). This shows the total claims with region code 25.
% POS	The number of POS claims, divided by the total number of ECC claims, multiplied by 100
Total ECC	The number of ECS claims plus the number of POS claims
Total Claims	Total paper claims plus total ECC

Note: Adjustment claims are reported in the type of media columns by the mother claim, not the adjustment claim.

REPORT: CLM-0115-M
PROCESS:
LOCATION:

IndianaAIM
CLAIM COUNT --Geographical Area
Period: CCYY/MM/DD - CCYY/MM/DD

DATE: CCYYMMDD
PAGE: 99,999

COUNTY CODE/COUNTY NAME	NO. COMPUTER GENERATED CLAIMS	NO. HANDWRITTEN CLAIMS	% COMPUTER GENERATED	TOTAL PAPER CLAIMS	NO. ECS BATCH CLAIMS	NO. POS CLAIMS	% POS	TOTAL ECC	% OF ECS TO TOTAL CLAIMS	TOTAL CLAIMS
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
XX - XXXXXXXXXXXXXXXXXX	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999	9999999
TOTAL	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999	99999999

END OF REPORT

CLM-0120-W Claim Correction Form by Claim Type

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0120-W		Claim Correction Form by Claim Type

Description of Information

The CLM-0120-W Claim Correction Form by Claim Type report lists each claim type, the claim type description, and the total number of CCFs produced for each claim type. A total line indicates the total number of CCFs produced for the week's cycle.

Purpose

The CLM-0120-W Claim Correction Form by Claim Type report is used by EDS and IFSSA to identify the number of Claim Correction Forms (CCFs) produced for each claim type.

Sort Sequence

- *Primary -* Claim type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly
FSSA	CRLD/Paper	1	Weekly

Detailed Field Definitions

CT — This is the one-byte field representing claim type. Valid values:

A–UB92 INST XOVER CLAIMS
B–CMS 1500 XOVER CLAIMS
C–UB92 OUTP XOVER CLAIMS
D–DENTAL CLAIMS
H–HOME HEALTH CLAIMS
I– INPATIENT CLAIMS
L–LONG TERM CARE CLAIMS
M–CMS 1500 CLAIMS
O–OUTPATIENT CLAIMS
P–PHARMACY CLAIMS
Q–COMPOUND DRUG CLAIMS

Description — Text which describes the claim type

CCFS — The number of CCFs generated in the past week's financial cycle for the particular claim type

Totals	The total number of CCFs generated in the past week's financial cycle for all claim types

Report: CLM-0120-W
Process: CLMJW120
Location:CLM0120W

Indiana*AIM*

Run Date: CCYY/MM/DD
Page No.: 99,999

CLAIM CORRECTION FORM
BY CLAIM TYPE
Period: MM/DD/CCYY - MM/DD/CCYY

CT	DESCRIPTION	CCFS
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
X	XXXXXXXXXXXXXXXXXXXXXXXX	9999
TOTALS		9999

End of Report

CLM-0125-W Claim Correction Form by Provider Type

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0125-W		Claim Correction Form by Provider Type

Description of Information

The CLM-0125-W Claim Correction Form by Provider Type report lists each provider type, the provider type description, and the total number of CCFs produced for each provider type. A total line indicates the total number of CCFs produced for the week's cycle.

Purpose

The CLM-0125-W Claim Correction Form by Provider Type report is used by EDS and IFSSA to identify the number of CCFs produced for each provider type.

Sort Sequence

- *Primary -* Provider type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly

Detailed Field Definitions

Prov Type

The two-byte provider type for which CCFs generated during the past week. Valid values:

01 Hospital
02 Ambulatory Surgical Center (ASC)
03 Extended Care Facility
04 Rehabilitation Facility
05 Home Health Agency
06 Hospice
07 Capitation Provider
08 Clinic
09 Advance Practice Nurse
10 Mid-Level Practitioner
11 Mental Health Provider
12 School Corporation
13 Public Health Agency
14 Podiatrist
15 Chiropractor
16 Nurse
17 Therapist
18 Optometrist
19 Optician
20 Audiologist
21 Case Manager (Targeted)
22 Hearing Aid Dealer
23 Dietitian
24 Pharmacy
25 DME/Medical Supply Dealer
26 Transportation Provider
27 Dentist
28 Laboratory
29 X-Ray Clinic
30 End-Stage Renal Disease (RSD) Clinic
31 Physician
32 Waiver Provider
33 Non-Billing Waiver Case Manager

Description

Text which describes the provider type

CCFS

The number of CCFs generated in the past week's financial cycle for the particular claim type

Totals

The total number of CCFs generated in the past week's financial cycle for all provider types

```
Report:  CLM-0125-W                                          IndianaAIM                   Run Date:  CCYY/MM/DD
Process: CLMJW125                                                                             Page No.:  99,999
Location:CLM0125W
                                                     CLAIM CORRECTION FORM
                                                        BY PROVIDER TYPE
                                                Period:  MM/DD/CCYY - MM/DD/CCYY



                                         PROV TYPE            DESCRIPTION                     CCFS

                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999
                                            99            XXXXXXXXXXXXXXXXXXX                 9999


                                          TOTALS                                             99999




                                                                   End of Report
```

CLM-0130-D CLM-0130-W Error Analysis by Error Code

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0130-D CLM-0130-W		Error Analysis by Error Code

Description of Information

The report shows how many times the listed ESC set during the reported period. This report does not count claims, it counts occurrences of the ESC codes. All edits that are suspending are listed under the error number column with a brief description. For each edit a total number of suspensions for all ESC codes and a total number by each claim type are listed.

Purpose

The Error Analysis by Error Code report is used by EDS and IFSSA to monitor daily edit suspensions for paper, ECS and POS (Point Of Service) claims. When high edit counts are identified, research is done to determine if edits need revision or if providers are experiencing billing problems. If a provider is identified as having problems, the provider relations area may contact the provider to help alleviate or resolve the problems

Sort Sequence

- *Primary -* Error status code

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	2	Daily

Detailed Field Definitions

ESC	The four-byte error status code that caused at least one claim to suspend during the reporting period
Desc	The description of the four-byte ESC. This field is 21 bytes in length.
CCF	The total number of CCFs sent out during the reporting period sorted by ESC
Total	The total number of times that this error status code set during the reporting period. It is sorted into the total of all paper claims, electronic claims, and POS.
Pharm	The total number of times that this error status code set for pharmacy claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim types reported in this column are **P** and **Q**.

Med	The total number of times that this error status code was set for medical claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **M**.
Dent	The total number of times that this error status code set for dental claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **D**.
Inpt	The total number of times this error status code set for inpatient claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **I**.
Outp	The total number of times this error status code set for outpatient claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **O**.
Lt Care	The total number of times this error status code set long term care claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **L**.
H Hlth	The total number of times this error status code set for home health claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **H**.
Xovr	The total number of times this error status code set for crossover claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim types that report in this column are **A**, **C**, and **B**.
Grand Total CCF	The total number of times CCFs generated on a daily basis for all ESCs reported during the reported period.
Grand Total	The total number of times all error status codes set during the reporting period. It is sorted into the total of all submissions of paper claims, electronic claims, and POS. This includes all claims types and prints one time at the end of the report

REPORT: CLM-0130-W IndianaAIM RUN DATE: CCYYMMDD
PROCESS: CLMJD130 ERROR ANALYSIS BY ERROR CODEPAGE: 99,999
LOCATION: CLM0130D Period: CCYY/MM/DD

ESC	DESC		CCF	TOTAL	PHARM	MEDI	DENT	INPAT	OUTP	LT CARE	H HLTH	XOVR
9999	XXXXXXXXXXXXXXXXXX	PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

ESC	DESC											
9999	XXXXXXXXXXXXXXXXXX	PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

ESC	DESC											
9999	XXXXXXXXXXXXXXXXXX	PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

GRAND TOTALS		PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

END OF REPORT

CLM-0131-W Error Analysis by Error Code

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0131-W		Error Analysis by Error Code

Description of Information

This report shows how many times the listed ESC set during the reported period. This report does not count claims, it counts occurrences of the ESC codes. All edits that are suspending are listed under the error number column with a brief description. For each edit a total number of suspensions for all ESC codes and a total number by each claim type are listed.

Purpose

The Error Analysis by Error Code report is used by EDS and IFSSA to monitor all edit suspensions for paper, ECS and POS (Point Of Service) claims that are in suspense. When high edit counts are identified, research is done to determine if edits need revision or if providers are experiencing billing problems. If a provider is identified as having problems, the provider relations area may contact the provider to help alleviate or resolve the problems

Sort Sequence

- *Primary -* Error status code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Weekly

Detailed Field Definitions

ESC	The four-byte error status code that caused at least one claim to suspend during the reporting period
Desc	The description of the four-byte ESC. This field is 21 bytes in length.
CCF	The total number of CCFs sent out during the reporting period sorted by ESC.
Total	The total number of times this error status code set during the reporting period. It is sorted into the total of all paper claims, electronic claims, and POS.
Pharm	The total number of times this error status code set for pharmacy claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim types that report in this column are **P** and **Q**.
Med	The total number of times this error status code set for medical claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **M**.

Dent	The total number of times this error status code set for dental claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **D**.
Inpat	The total number of times this error status code set for inpatient claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **I**.
Outp	The total number of times this error status code set for outpatient claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **O**.
Lt Care	The total number of times this error status code set long term care claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **L**.
H Hlth	The total number of times this error status code set for home health claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim type that reports in this column is **H**.
Xovr	The total number of times this error status code set for crossover claims. It is sorted into the total of all paper claims, electronic claims, and POS. The claim types that report in this column are **A**, **C**, and **B**.
Grand Total CCF	The total number of times CCFs generated on a daily basis for all ESCs reported during the reported period.
Grand Total	The total number of times all error status codes were set during the reporting period. It is sorted into the total of all submissions of paper claims, electronic claims, and POS. This includes all claims types and prints one time at the end of the report

REPORT: CLM-0131-W
PROCESS: CLMJW131
LOCATION: CLM0131W

IndianaAIM
ERROR ANALYSIS BY ERROR CODE
Week Ending: CCYY/MM/DD

RUN DATE: CCYYMMDD
PAGE: 99,999

ESC	DESC		CCF	TOTAL	PHARM	MEDI	DENT	INPAT	OUTP	LT CARE	H HLTH	XOVR
9999	XXXXXXXXXXXXXXXXXX	PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

ESC	DESC											
9999	XXXXXXXXXXXXXXXXXX	PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

ESC	DESC											
9999	XXXXXXXXXXXXXXXXXX	PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
	XXXXXXXXXXXXXXXXXX	POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

GRAND TOTALS		PAPER	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ECS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		POS	9999	9999	9999	9999	9999	9999	9999	9999	9999	
		ALL MEDIA	9999	9999	9999	9999	9999	9999	9999	9999	9999	9999

END OF REPORT

CLM-0135-W Error Analysis by Provider Number

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0135-W		Error Analysis by Provider Number

Description of Information

The report lists the top ten provider numbers and their top five error status codes. It also lists the top ten provider numbers for 590 Program denied claims and their top five error status codes.

Purpose

The Error Analysis by Provider Number report is used by EDS to examine the top ten Providers who encountered the most errors in the claims processing system. It monitors the top five error status codes by provider number. This report is forwarded to provider relations so that they can notify the affected providers of the errors encountered. This request is to modify this report to include and list separately providers billing for 590 Program services.

Sort Sequence

- *Primary* - Provider number
- *Secondary* - Error status codes

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Weekly

Detailed Field Definitions

Provider No.	The provider's nine-byte Medicaid identification number
ESC	The four-byte error status code

```
REPORT:  CLM-0135-W                              IndianaAIM                  DATE: CCYYMMDD
PROCESS:                                 ERROR ANALYSIS BY PROVIDER          PAGE: 99,999
LOCATION:


                                PROVIDER NO.      ESC

                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
                                 999999999        9999    9999   9999   9999        9999
```

ERROR ANALYSIS BY 590 PROVIDER

```
                               PROVIDER NO.      ESC

                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
                               999999999         9999    9999    9999  9999    9999
```

CLM-0140-W Error Analysis by Forced Error Code

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0140-W		Error Analysis by Forced Error Code

Description of Information

For each claim, the report lists the error code, description, and number of errors per claim type forced through the system. All edits forced are listed under the error number column with a brief description. The report gives totals for the number of forced transactions for each claim type, for each edit, and for all claims.

Purpose

EDS and the IFFSA use the Error Analysis by Forced Error Code report to monitor the effectiveness of the error codes. It also determines whether error codes are needed, depending on the volume of claims forced to adjudicate and pay.

Sort Sequence

- *Primary -* Error status code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly

Detailed Field Definitions

ESC	The four-byte error status code that caused at least one claim to suspend during the past week
Desc	The description of the four-byte ESC
Total	The total number of times this error status code was forced during the past week. It is sorted by the total of all paper claims, electronic claims, and POS.
Pharm	The total number of times this error status code was forced for pharmacy claims. It is sorted by the total of all paper claims, electronic claims, and POS.
Med	The total number of times this error status code was forced for medical claims. It is sorted by the total of all paper claims, electronic claims, and POS.
Dent	The total number of times this error status code was forced for dental claims. It is sorted by the total of all paper claims, electronic claims, and POS.

Inpat	The total number of times this error status code was forced for inpatient claims. It is sorted by the total of all paper claims, electronic claims, and POS.
Outp	The total number of times this error status code was forced for outpatient claims. It is sorted by the total of all paper claims, electronic claims, and POS.
Lt Care	The total number of times this error status code was forced for long-term care claims. It is sorted by the total of all paper claims, electronic claims, and POS.
H Hlth	The total number of times this error status code was forced for home health claims. It is sorted by the total of all paper claims, electronic claims, and POS.
XOvr	The total number of times this error status code was forced for Xover claims. It is sorted by the total of all paper claims, electronic claims, and POS.
Grand Total	The total number of times all error status codes were forced during the past week. It is sorted by the total of all submissions of paper claims, electronic claims, and POS. This includes all claims types and prints one time at the end of the report.

```
REPORT: CLM-0140-W                       IndianaAIM                                 DATE: CCYYMMDD
PROCESS:                     ERROR ANALYSIS BY FORCED ERROR CODE                     PAGE: 99,999
LOCATION:


ESC         DESC                              TOTAL    PHARM    MEDI    DENT    INPAT    OUTP    LT CARE   H HLTH   XOVR

9999        XXXXXXXXXXXXXXXXXX   PAPER        9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   ECS          9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   POS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ALL MEDIA    9999     9999     9999    9999    9999     9999    9999      9999     9999

ESC         DESC                              TOTAL    PHARM    MEDI    DENT    INPAT    OUTP    LT CARE   H HLTH   XOVR

9999        XXXXXXXXXXXXXXXXXX   PAPER        9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   ECS          9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   POS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ALL MEDIA    9999     9999     9999    9999    9999     9999    9999      9999     9999

ESC         DESC                              TOTAL    PHARM    MEDI    DENT    INPAT    OUTP    LT CARE   H HLTH   XOVR

9999        XXXXXXXXXXXXXXXXXX   PAPER        9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   ECS          9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   POS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ALL MEDIA    9999     9999     9999    9999    9999     9999    9999      9999     9999

ESC         DESC                              TOTAL    PHARM    MEDI    DENT    INPAT    OUTP    LT CARE   H HLTH   XOVR

9999        XXXXXXXXXXXXXXXXXX   PAPER        9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   ECS          9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   POS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ALL MEDIA    9999     9999     9999    9999    9999     9999    9999      9999     9999

ESC         DESC                              TOTAL    PHARM    MEDI    DENT    INPAT    OUTP    LT CARE   H HLTH   XOVR

9999        XXXXXXXXXXXXXXXXXX   PAPER        9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   ECS          9999     9999     9999    9999    9999     9999    9999      9999     9999
            XXXXXXXXXXXXXXXXXX   POS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ALL MEDIA    9999     9999     9999    9999    9999     9999    9999      9999     9999


GRAND TOTALS                     PAPER        9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ECS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 POS          9999     9999     9999    9999    9999     9999    9999      9999     9999
                                 ALL MEDIA    9999     9999     9999    9999    9999     9999    9999      9999     9999
```

CLM-0145-D Error Analysis by Denied Error Code

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0145-D	CLMJD145	Error Analysis by Denied Error Code

Description of Information

EDS and IFSSA use the Error Analysis by Denied Error Code report to monitor daily edit denials by paper, ECS, and POS (Point Of Service) claims. When high claim denials are identified, research is done to determine if edits need revision or if providers are experiencing billing problems. If a provider is having problems, the resolutions department contacts the provider relations area to notify providers of their billing errors.

Purpose

The report shows the number of ESC codes per claim type that denied. All edits that are denying are listed under the error number column with a brief description. For each edit a total number of denials for all claims and a total number by each claim type are listed.

Sort Sequence

- *Primary -* Error status code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Daily

Detailed Field Definitions

ESC	The four-byte error status code that caused at least one claim to deny that day
Desc	The description of the four-byte denied ESC
Total	The total number of times this error status code denied that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC.
Pharm	The total number of times this error status code denied for pharmacy claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim types in this count are **P** and **Q**.
Med	The total number of times this error status code denied for medical claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim type in this count is **M**.

Dent	The total number of times this error status code denied for dental claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim type in this count is **D**.
Inpat	The total number of times this error status code denied for inpatient claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim type in this count is **I**.
Outp	The total number of times this error status code denied for outpatient claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim type included in this count is **O**.
Lt Care	The total number of times this error status code denied for long-term care claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim type in this count is **L**.
H Hlth	The total number of times this error status code denied for home health claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim type in this count is **H**.
XOvr	The total number of times this error status code denied for crossover claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials for the ESC. Claim types in this count are A, B, C.
Grand Total	The total number of times all error status codes reported denied for all claim types that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.
Grand Total Pharm	The total number of times all error status codes reported denied for pharmacy claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.
Grand Total Med	The total number of times all error status codes reported denied for medical claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.
Grand Total Dent	The total number of times all error status codes reported denied for dental claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.
Grand Total Inpat	The total number of times all error status codes reported denied for inpatient claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.

Grand Total Outp	The total number of times all error status codes reported denied for outpatient claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.
Grand Total Lt Care	The total number of times all error status codes reported denied for long-term care claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.
Grand Total H Hlth	The total number of times all error status codes reported denied for home health claims that day. Sorted by the total number of paper, electronic, and POS claims denied. All media is the sum of the paper, electronic, and POS denials.

```
REPORT: CLM-0145-D                            IndianaAIM                                    DATE:   CCYYMMDD
PROCESS:                          ERROR ANALYSIS BY DENIED ERROR CODE                       PAGE:     99,999
LOCATION:                          Period:  MM/DD/CCYY - MM/DD/CCYY

ESC     DESC                                  TOTAL   PHARM   MED     DENT    INPAT   OUTP      LT CARE  H HLTH   XOVR

9999    XXXXXXXXXXXXXXXXXX    PAPER           9999    9999    9999    9999    9999    9999      9999     9999     9999
        X
        XXXXXXXXXXXXXXXXXX
        X
        XXXXXXXXXXXXXXXXXX    ECS             9999    9999    9999    9999    9999    9999      9999     9999     9999
        X
                              POS             9999    9999    9999    9999    9999    9999      9999     9999     9999

                              ALL MEDIA       9999    9999    9999    9999    9999    9999      9999     9999     9999

ESC     DESC                                  TOTAL   PHARM   MED     DENT    INPAT   OUTP      LT CARE  H HLTH   XOVR

9999    XXXXXXXXXXXXXXXXXX    PAPER           9999    9999    9999    9999    9999    9999      9999     9999     9999
        X
        XXXXXXXXXXXXXXXXXX
        X
        XXXXXXXXXXXXXXXXXX    ECS             9999    9999    9999    9999    9999    9999      9999     9999     9999
        X
                              POS             9999    9999    9999    9999    9999    9999      9999     9999     9999

                              ALL MEDIA       9999    9999    9999    9999    9999    9999      9999     9999     9999

ESC     DESC                                  TOTAL   PHARM   MED     DENT    INPAT   OUTP      LT CARE  H HLTH   XOVR


9999    XXXXXXXXXXXXXXXXXX    PAPER           9999    9999    9999    9999    9999    9999      9999     9999     9999
        X
        XXXXXXXXXXXXXXXXXX
        X
        XXXXXXXXXXXXXXXXXX    ECS             9999    9999    9999    9999    9999    9999      9999     9999     9999
        X
                              POS             9999    9999    9999    9999    9999    9999      9999     9999     9999

                              ALL MEDIA       9999    9999    9999    9999    9999    9999      9999     9999     9999

        GRAND TOTALS          PAPER           9999    9999    9999    9999    9999    9999      9999     9999     9999

                              ECS             9999    9999    9999    9999    9999    9999      9999     9999     9999

                              POS             9999    9999    9999    9999    9999    9999      9999     9999     9999

                              ALL MEDIA       9999    9999    9999    9999    9999    9999      9999     9999     9999
```

END OF REPORT

CLM-0150-W EOB Denial Analysis List

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0150-W		EOB Denial Analysis List

Description of Information

The report lists, for each claim, the error code, description, and the EOB posted to the claim when it denied. The total number of denials for each error code is displayed and the number of denials per claim type is reported in the claim type columns. At the end of the report is the grand total number of auto-denials and manual denied claims.

Purpose

EDS and IFSSA use the EOB Denial Analysis List report to identify the number of claims that were auto-denied and manually denied in the last weekly cycle. The error status codes (ESC) that cause claims to be auto-denied can be found on the Edit/Audit Disposition Table. ESCs that cause claims to be manually denied are set to suspend on the error disposition table.

Sort Sequence

- *Primary* - ESC
- *Secondary* - EOB

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly

Detailed Field Definitions

ESC	The four-byte error status code that caused at least one claim to auto-deny during the week
EOB	The four-byte explanation of benefit code assigned to the ESC when it is set to auto-deny
Desc	The description of the four-byte ESC
Total	The number of times this ESC auto-denied in this past financial cycle (all claim types)
Pharm	The total number of times this error status code auto-denied for pharmacy claims
Med	The total number of times this error status code auto-denied for medical claims

Dent	The total number of times this error status code auto-denied for dental claims.
Inpat	The total number of times this error status code auto-denied for inpatient claims
Outp	The total number of times this error status code auto-denied for outpatient claims
Lt Care	The total number of times this error status code auto-denied long term claims
H Hlth	The total number of times this error status code auto-denied for home health claims
XOvr	The total number of times this error status code auto-denied for crossover claims
Total Errors	The number of auto-denials for all error status codes in the past financial cycle for all claim types, sorted by claim type
ESC	The four-byte error status code that caused at least one claim to manually deny during the past week. ESCs set to suspend on the error disposition table require manual examination of the claim. Claims are checked for validity and completeness; if the claim does not meet the criteria of the ESC it may result in the denial of the claim.
EOB	The four-byte explanation of benefit code assigned to the ESC
Desc	The description of the four-byte ESC
Total	The number of times this ESC manually denied in the past financial cycle (all claim types)
Pharm	The total number of times this error status code manually denied for pharmacy claims
Med	The total number of times this error status code manually denied for medical claims
Dent	The total number of times this error status code manually denied for dental claims
Inpat	The total number of times this error status code manually denied for inpatient claims
Outp	The total number of times this error status code manually denied for outpatient claims
Lt Care	The total number of times this error status code manually denied long-term care claims.
H Hlth	The total number of times this error status code manually denied for home health claims

XOvr	The total number of times this error status code manually denied for crossover claims
Total Errors	The number of manual denials for all error status codes in the past financial cycle for all claim types, sorted by claim type
Grand Total	The number of manual and auto-denials that occurred for the past financial cycle for all claim types, sorted by claim type.

```
REPORT: CLM-0150-W                    IndianaAIM                              DATE: CCYYMMDD
PROCESS:                       EOB DENIAL ANALYSIS LIST                       PAGE: 99,999
LOCATION:


        AUTO DENIED CLAIMS

ESC     DESC                            EOB     TOTAL   PHARM   MED     DENT    INPAT   OUTP    LTC     H HLTH  XOVR
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
        TOTAL ERRORS AUTO DENIED        9999    9999    9999    9999    9999    9999    9999    9999    9999    9999


        MANUALLY DENIED CLAIMS

ESC     DESC                            EOB     TOTAL   PHARM   MED     DENT    INPAT   OUTP    LTC     H HLTH  XOVR
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
9999    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
        TOTAL ERRORS MANUALLY DENIED    9999    9999    9999    9999    9999    9999    9999    9999    9999    9999


        GRAND TOTAL ERRORS DENIED       9999    9999    9999    9999    9999    9999    9999    9999    9999    9999
```

CLM-0155-M Edit/Audit Override Analysis

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0155-M		Edit/Audit Override Analysis

Description of Information

The report contains the clerk ID who overrode the error, the claim type on which the error occurred, the error code and the number of claims that had that error code overridden, the frequency of the overrides.

Purpose

The CLM-0155-M Edit/Audit Override Analysis report is used by EDS and IFSSA to identify which error codes are overridden.

Sort Sequence

- *Primary* - Clerk ID
- *Secondary* - Claim type
- *Tertiary* - ESC

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly

Detailed Field Definitions

Clerk ID — The three-byte clerk ID of the resolutions clerk who overrode the error status code listed. Print only the first occurrence of each clerk ID.

CT — The one-byte claim type in which the clerk had at least one claim override in the past month. Valid values:

D—Dental
E—Encounter
L—Long term care
M—CMS-1500
I—Inpatient
O—Outpatient
P—Pharmacy
X—Crossover A, B, and C

ESC — The four-byte error status code that the clerk overrode. Only error status codes that are overridden at least once are displayed.

Num Of Claims — The number of claims that the clerk overrode with that error status code

Total Num Of Claims — The total number of claims overridden by each clerk for the period reported

Total Overrides — The total number of claims overridden by all clerks for the period reported

Report: CLM-0155-M **Indiana*AIM*** DATE: CCYYMMDD
Process: **EDIT/AUDIT OVERRIDE ANALYSIS** PAGE: 99,999
Location:

CLERK ID	CT	ESC	NUM OF CLAIMS
XXX	X	9999	9999
XXX	X	9999	9999
XXX	X	9999	9999
XXX	X	9999	9999
TOTAL			9999
XXX	X	9999	9999
XXX	X	9999	9999
XXX	X	9999	9999
XXX	X	9999	9999
TOTAL			9999
XXX	X	9999	9999
XXX	X	9999	9999
XXX	X	9999	9999
XXX	X	9999	9999
TOTAL			9999
TOTAL OVERRIDES			99999

CLM-0160-W Specially Handled And Processed Claims

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0160-W		Specially Handled And Processed Claims

Description of Information

The CLM-0160-W Specially Handled And Processed Claims report identifies claims processed for payment through Indiana*AIM* with special considerations requested by IFSSA or EDS. The claims reported are identified with a Region Code of 90 (Special Handling). The report lists each claim ICN that was specially processed, the provider number, RID No., from and through dates of service, billed amount, and paid amount.

Purpose

The IFSSA and EDS use the Specially Handled And Processed Claims report to identify claims processed for payment through Indiana*AIM* with special considerations.

Sort Sequence

- *Primary -* Provider

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	3	Weekly
FSSA	CRLD/Paper	1	Weekly

Detailed Field Definitions

ICN	A number assigned to a claim processed in the system used for internal control
Prov	A system-assigned number used to uniquely identify a provider
RID No	A system-assigned number used to uniquely identify a recipient
FDOS	The from date of service on the claim
TDOS	The through date of service on the claim
Bld Amt.	The billed amount on the claim
Pd Amt.	The paid amount of the claim if it was adjudicated during the past week's financial cycle

```
Report:  CLM-0160-W                         IndianaAIM                            Run Date:  CCYY/MM/DD
Process:                                                                             Page No.:  99,999
Location
                                    SPECIALLY HANDLED AND PROCESSED CLAIMS


                        ICN            PROV          RID NO.          FDOS        TDOS        BLD AMT          PD AMT

                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
                   9999999999999     999999999     999999999999     MMDDCCYY    MMDDCCYY    $,$$$,$$9.99    $,$$$,$$9.99
```

End of Report

CLM-0161-D Handled Suspended Daily Claims Report

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0161-D		Handled Suspended Daily Claims Report

Description of Information

The CLM-01601D Specially Handled And Suspended Claims report identifies claims suspended for review through Indiana*AIM* with special considerations requested by FSSA or EDS. The claims reported are identified with a Region Code of 90 (Special Handling). The report lists each claim ICN that was specially processed, the provider number, RID No., from and through dates of service, billed amount, and claim location.

Purpose

The IFSSA and EDS use the Specially Handled And Suspended Claims report to identify claims that have suspended for review through Indiana*AIM* with special considerations.

Sort Sequence

- *Primary -* Provider

Distribution

To	Media	Copies	Frequency
EDS	CRLD	0	Daily
IFSSA	CRLD	0	Daily

Detailed Field Definitions

ICN	A number assigned to a claim processed in the system used for internal control
Prov	A system-assigned number used to uniquely identify a provider
RID No.	A system-assigned number used to uniquely identify a recipient
FDOS	The from date of service on the claim
TDOS	The through date of service on the claim
Bld Amt	The billed amount on the claim
Location	The location of the claim when it suspended

Report: CLM-0161-D
Process:
Location

Indiana*AIM*

Run Date: MM/DD/CCYY
Page No.: 99,999
Run Time: 99:99:99

SPECIALLY HANDLED AND SUSPENDED CLAIMS

ICN	PROV	RID NO.	FDOS	TDOS	BLD AMT	LOCATION
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99
9999999999999	999999999	999999999999	MMDDCCYY	MMDDCCYY	$,$$$,$$9.99	99

End of Report

CLM-0165-W, CLM-0165-P, CLM-0165-E, CLM-0165-S Weekly Claim Adjudication Cycle Time Report

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0165-W CLM-0165-P CLM-0165-E CLM-0165-S		Weekly Claim Adjudication Cycle Time Report

Description of Information

The report lists claim counts by claim type, the number of days to reach final status. Final status is reached when claims hit locations: 66—denied, 98—approved for payment, or 99—paid for each media type (paper, electronic claim submission (ECS), and point of service (POS)). This report also lists the percentage of total claim volume by days elapsed and the average age of claims in final status. Data reported spans 30 days.

Purpose

EDS and IFSSA use the Weekly Claim Adjudication Cycle Time report to monitor the claims processing time.

Sort Sequence

- *Primary* - Region code
- *Secondary* - Claim type
- *Tertiary* - Location code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Weekly
IFSSA	CRLD/Paper	1	Weekly

Detailed Field Definitions

Media Type — This report is generated for paper (region code 10 and 11), ECS (region codes 20, 21, 23, and 90), POS (region codes 25 and 26), and for paper, ECS, and POS claims combined.

Days — Days taken for claims to reach final status, from one day to the greatest number of days required.

Claim Type

This field represents claim type. Valid values:

- Pharmacy
- CMS-1500
- Dental
- Inpatient
- Outpatient
- Long-term care
- Home health
- Crossovers A, B, and C

Claims counts and their respective percentage of the total claims processed for the day are listed below each claim type. **G** prints next to each claim type's percent column on the day 30 row to indicate the goal of 100 percent adjudication in 30 days. ***** prints next to each claim type's percent column on the row where 100 percent adjudication was met. Claim counts below this row equal zero

Totals

The total number of claims processed for each claim type and all claim types during the 30-day reporting period.

Standard

The RFP requires that 100 percent of claims in suspense be processed within 30 days. Excluded from this standard are claims in locations: 22—Medical Policy, 40—CCF, 42—HOLD, 43—IFSSA, 44—CHSCS. Days in these locations are not included in the total number of days in suspense.

Actual

Percent of total volume by claim type that reached final status in 30 days.

Average

The average number of days taken for all claims in each claim type to reach final status during the reporting period.

Monthly Summary

All data reflects the previous calendar month's claim adjudication performance for all claim types.

```
Report:  CLM-0165-W                                        IndianaAIM                                            DATE:  CCYYMMDD
Process:                                   WEEKLY CLAIM ADJUDICATION CYCLE TIME REPORT                               PAGE: 99,999
Location:                                                  ALL MEDIA

    DAYS     PHARMACY    HCFA 1500      DENTAL       INPATIENT     OUTPATIENT      LTC         HOME         HEALTH      CROSSOVER   ALL CLM TYPES
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
     999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
              99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
  TOTALS:   999999999   999999999     999999999     999999999     999999999    999999999    999999999    999999999    999999999     999999999
 STANDARD:  100%-30 DAYS

 ACTUAL:   999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99%

 AVERAGE DAYS:99.9        99.9          99.9          99.9          99.9         99.9         99.9         99.9         99.9
```

```
      Report:  CLM-0165-W                                       IndianaAIM                                            DATE:  CCYYMMDD
      Process:                                  WEEKLY CLAIM ADJUDICATION CYCLE TIME REPORT                              PAGE: 99,999
      Location:                                                 PAPER CLAIMS

   DAYS    PHARMACY    HCFA 1500      DENTAL       INPATIENT     OUTPATIENT      LTC         HOME         HEALTH      CROSSOVER   ALL CLM TYPES
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999       9999999      9999999      9999999       9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99        99.99        99.99         99.99        99.99         99.99
 TOTALS:   999999999   999999999     999999999     999999999     999999999    999999999    999999999     999999999    999999999     999999999
STANDARD:  100%-30 DAYS

ACTUAL:  999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99%

AVERAGE DAYS:99.9        99.9          99.9          99.9           99.9         99.9         99.9          99.9         99.9
```

```
Report:  CLM-0165-W                                   IndianaAIM                                              DATE:  CCYYMMDD
Process:                              WEEKLY CLAIM ADJUDICATION CYCLE TIME REPORT                                PAGE: 99,999
Location:                                             ECS CLAIMS

   DAYS     PHARMACY    HCFA 1500      DENTAL       INPATIENT     OUTPATIENT      LTC          HOME         HEALTH      CROSSOVER   ALL CLM TYPES
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
    999     9999999     9999999       9999999       9999999       9999999       9999999      9999999      9999999      9999999       9999999
             99.99       99.99         99.99         99.99         99.99         99.99        99.99        99.99        99.99         99.99
 TOTALS:   999999999   999999999     999999999     999999999     999999999     999999999    999999999    999999999    999999999     999999999
STANDARD:  100%-30 DAYS

ACTUAL:  999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99%

AVERAGE DAYS:99.9        99.9          99.9          99.9          99.9          99.9         99.9         99.9         99.9
```

```
      Report:  CLM-0165-W                                        IndianaAIM
                                                                                                                       DATE:  CCYYMMDD
      Process:                                  WEEKLY CLAIM ADJUDICATION CYCLE TIME REPORT                               PAGE: 99,999
      Location:                                                  POS CLAIMS

   DAYS    PHARMACY    HCFA 1500      DENTAL       INPATIENT     OUTPATIENT       LTC         HOME         HEALTH      CROSSOVER   ALL CLM TYPES
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
   999      9999999     9999999       9999999       9999999        9999999      9999999     9999999        9999999      9999999       9999999
             99.99       99.99         99.99         99.99          99.99        99.99       99.99          99.99        99.99         99.99
 TOTALS:   999999999   999999999     999999999     999999999      999999999    999999999   999999999      999999999    999999999     999999999
STANDARD:  100%-30 DAYS

ACTUAL:  999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99%

AVERAGE DAYS:99.9        99.9          99.9          99.9            99.9         99.9         99.9          99.9         99.9
```

```
    Report:  CLM-0165-W                               IndianaAIM                                         DATE:  CCYYMMDD
    Process:                  WEEKLY CLAIM ADJUDICATION CYCLE TIME REPORT - MONTHLY SUMMARY                PAGE: 99,999
    Location:                                          ALL MEDIA

 DAYS    PHARMACY   HCFA 1500     DENTAL       INPATIENT     OUTPATIENT     LTC         HOME         HEALTH      CROSSOVER   ALL CLM TYPES
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
  999     9999999    9999999      9999999       9999999       9999999     9999999      9999999      9999999      9999999      9999999
            99.99      99.99        99.99         99.99         99.99       99.99        99.99        99.99        99.99        99.99
TOTALS:  999999999  999999999    999999999     999999999     999999999   999999999    999999999    999999999    999999999    999999999
STANDARD:  100%-30 DAYS

ACTUAL:  999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99% 999.99%

AVERAGE DAYS:99.9      99.9          99.9          99.9          99.9        99.9         99.9         99.9         99.9
```

CLM-0175-W Weekly Claim Payment

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0175-W		Weekly Claim Payment

Description of Information

This report shows the total dollar amount, per claim type, paid to the provider community for the previous week and is reported on the checkwrite date. Month to date, fiscal year to date, and calendar year to date summaries are also reported by claim type.

Purpose

The Weekly Claim Payment report is used by EDS and IFSSA to monitor weekly provider payments.

Sort Sequence

- *Primary -* Claim type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	3	Weekly
FSSA	CRLD/Paper	1	Weekly

Detailed Field Definitions

Date

The checkwrite date for each week reported

Claim Type

Valid values:

Pharmacy
CMS-1500
Dental
Inpatient
Nursing home
Outpatient
Home health
Crossover

Each column shows the dollar amount paid to the provider community for each claim type for the week, month, and fiscal and calendar year. All claim types column shows week, month-to-date, and fiscal and calendar year totals for all claim types.

MTD

Month-to-date summarizes the claim payments for each month. MTD prints on every checkwrite date.

Fiscal Year-To-Date

First checkwrite date in July through the last checkwrite date in June. FYTD prints on every checkwrite date.

Calendar Year-To-Date

First checkwrite date in January through the last checkwrite date in December. CYTD prints on every checkwrite date.

```
    REPORT:  CLM-0175-W                        IndianaAIM                                DATE: CCYYMMDD
    PROCESS:                            WEEKLY CLAIM PAYMENT SUMMARY                      PAGE: 99,999
    LOCATION:                           PERIOD MMDDCCYY - MMDDCCYY

DATE        PHARMACY        HCFA 1500       DENTAL         INPATIENT       NURSING HOME     OUTPATIENT      HOME HEALTH     CROSSOVER       ALL CLAIM TYPES
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99

MTD       99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99

99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99

MTD       99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99

99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99
99/99/99  99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99

MTD       99,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99   999,999,999.99  99,999,999.99  99,999,999.99  99,999,999.99  9,999,999,999.99

FISCAL YEAR-TO-DATE      PHARMACY   9,999,999,999.99          NURSING HOME   9,999,999,999.99

                        HCFA 1500   9,999,999,999.99            OUTPATIENT   9,999,999,999.99
                           DENTAL   9,999,999,999.99           HOME HEALTH   9,999,999,999.99
                        INPATIENT   9,999,999,999.99             CROSSOVER   9,999,999,999.99
                                                           ALL CLAIM TYPES  99,999,999,999.99

CALENDAR YEAR-TO-DATE    PHARMACY   9,999,999,999.99          NURSING HOME   9,999,999,999.99

                        HCFA 1500   9,999,999,999.99            OUTPATIENT   9,999,999,999.99
                           DENTAL   9,999,999,999.99           HOME HEALTH   9,999,999,999.99
                        INPATIENT   9,999,999,999.99             CROSSOVER   9,999,999,999.99
                                                           ALL CLAIM TYPES  99,999,999,999.99
```

CLM-0180-D Suspended ICNs Requiring Batches

Functional Area	Report Number	Job Name	Report Title
Resolutions	CLM-0180-D		Suspended ICNs Requiring Batches

Description of Information

This report provides a listing of suspended ICNs which require a batch be pulled.

Purpose

The resolutions team uses this report to pull the necessary batches for each clerk.

Sort Sequence

- *Primary -* Clerk ID
- *Secondary -* ICN

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Daily

Detailed Field Definitions

Report Date	The date being reported
Clerk ID	The clerk ID number to whom the suspended ICN is assigned in the scheduler
ICN	A listing of all ICNs assigned to the clerk that have a batch indicator of **Y** in the scheduler

```
Report:CLM-0180-D                                   IndianaAIM                                 RUN DATE:mm/dd/ccyy
Process:XXXXXXXX                         Suspended ICNS Requiring Batches                      RUN TIME:99:99:99.9
Location:XXXXXXXX                            Report Date:  MM/DD/CCYY                                      PAGE:99

Clerk ID:XXXXXXX

                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999

                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999

                 Clerk ID:XXXXXXX

                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
                 9999999999999       9999999999999       9999999999999       9999999999999       9999999999999
```

CLM-0185-D Daily Claim Activity

Functional Area	Report Number	Job Name	Report Title
Claims	CLM-0185-D		Daily Claim Activity

Description of Information

The Daily Claim Activity report provides information on claims, suspense, and adjustments in regard to beginning inventory, new inventory, number processed , and ending inventory.

Purpose

EDS uses this report to balance claim and financial cycles. It provides the Claims Manager with the information needed to manage existing and new inventory.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Daily
IFSSA	CRLD	1	Daily

Detailed Field Definitions

Claims	Refers to original claims, not adjustments. Original Claims are identified by all regions ≠ 45-59.
Beginning	The number of sequences activated but not keyed. Status = O (open). Equals previous day's Ending
New	The number of sequences activated plus inactive claims keyed plus ECS claims and crossover tapes received
Processed	The number of claims processed (paid, denied, suspended, deleted*) during the current cycle. *Deleted claims are ICN sequences deleted from the control file. For example surplus ICN sequences resulting from over-activated batches must be deleted
Ending	Beginning + New - Processed = Ending. All sequences with Status = O after EOD runs. Equals Beginning for the next day
Suspended Claims By Location	Suspended Claims By Location are claims whose regions ≠ 45-59 and reside in locations 00-44.

Beginning	The number of claims that reside in the suspense file after the previous day's EOD. Equals the previous day's Ending.
New	Claims dispositioned to suspend during the current cycle (New claims and data corrections that dispositioned to suspend)
Processed	Claims previously in a suspense location processed (paid, denied, and suspended) during the current cycle
Ending	Beginning + New - Processed = Ending. This will become the next day's Beginning Suspense.
New Adjustments By Region	New Adjustments By Region are claims with regions = 45-59.
Beginning	All adjustments initiated at one time but not finalized from the previous day. Equals previous day's Ending
New	The number of adjustments initiated during the current cycle. Refer to ADJ-2000-D Adjustments Initiated.
Processed	The number of adjustments processed (paid, denied, suspended, Returned to Sender (RTS)) during the current cycle
Ending	Beginning Inventory + Total Receipts - Total Processed = Ending Inventory. Equals Beginning for the next day.
Suspended Adjustments By Region	Suspended adjustments are claims with regions = 45-59 and reside in locations 00-44.
Beginning	The number of adjustments that reside in the suspense file after the previous day's EOD. Equals the previous day's Ending
New	Adjustments dispositioned to suspend during the current cycle (such as adjustments released into suspense and data corrected adjustments dispositioned to suspend)
Processed	Adjustments previously in a suspense location processed (paid, denied, and suspended) during the current cycle
Ending	Beginning + New - Processed = Ending. This becomes the next day's Beginning Suspense.
Paper	ICNs with region codes 10, 11, 40, 41 (where batch <> 40/41 batches below) and 90.
POS/ECS	ICNs with region codes 20, 22, 25, 40, 41 (reg. 40/41 with batches 1-49, 56-199, 800-829, 850-999), and 80.

Report: CLM-0185-D
Process: CCL4JD185
Location: CLM0185D

IndianaAIM
DAILY CLAIM ACTIVITY
Period: mm/dd/ccyy
Actual Run Date: mm/dd/ccyy

Run Date: mm/dd/ccyy
Page:9999
Run Time: hh:mm:ss

CLAIMS	BEGINNING		NEW		PROCESSED		ENDING	
	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS
Inpatient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Outpatient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Medical	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Dental	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Pharmacy	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999

SUSPENDED CLAIMS BY LOCATION	BEGINNING	NEW	PROCESSED	ENDING
00 Validity	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999
04 Procedure code	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999
21 Medical policy	999,999	999,999	999,999	999,999
22 Medical review	999,999	999,999	999,999	999,999
23 Special Manual Pricing	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999

Report: CLM-0185-D
Process: CCL4JD185
Location: CLM0185D

IndianaAIM
DAILY CLAIM ACTIVITY
Period: mm/dd/ccyy
Actual Run Date: mm/dd/ccyy

Run Date: mm/dd/ccyy
Page:9999
Run Time: hh:mm:ss

NEW ADJUSTMENTS BY REGION

REGION	BEGINNING	NEW	PROCESSED	ENDING
45 Converted Adjustments	999,999	999,999	999,999	999,999
46 Converted 590 Adjustments	999,999	999,999	999,999	999,999
50 Non-check related adjustments	999,999	999,999	999,999	999,999
51 Check related adjustments	999,999	999,999	999,999	999,999
54 Mass Adjustments - Void txns	999,999	999,999	999,999	999,999
55 Mass Adjustment - Retro rate	999,999	999,999	999,999	999,999
56 Mass Adjustments	999,999	999,999	999,999	999,999
57 Adjustments reprocessed by EDS	999,999	999,999	999,999	999,999
58 Open	999,999	999,999	999,999	999,999
59 Open	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999

SUSPENDED ADJUSTMENTS BY LOCATION

LOCATION	BEGINNING	NEW	PROCESSED	ENDING
00 Validity	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999
04 Procedure code	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999
21 Medical policy	999,999	999,999	999,999	999,999
22 Medical review	999,999	999,999	999,999	999,999
23 Special Manual Pricing	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999

Report: CLM-0185-D
Process: CCL4JD185
Location: CLM0185D

IndianaAIM
DAILY CLAIM ACTIVITY
Period: mm/dd/ccyy
Actual Run Date: mm/dd/ccyy

Run Date: mm/dd/ccyy
Page:9999
Run Time: hh:mm:ss

INPATIENT	BEGINNING		NEW		PROCESSED		ENDING	
	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS
CLAIMS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
SUSPENDED CLAIMS BY LOCATION								
00 Validity	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
04 Procedure Code	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
21 Medical Policy	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
22 Medical Review	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
23 Manual Pricing	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
NEW ADJUSTMENTS BY REGION								
45 Converted Adjustments	999,999		999,999		999,999		999,999	
46 Converted 590 Adjustments	999,999		999,999		999,999		999,999	
50 Non-check related Adjustments	999,999		999,999		999,999		999,999	
51 Check related Adjustments	999,999		999,999		999,999		999,999	
54 Mass Adjustments-Void txns	999,999		999,999		999,999		999,999	
55 Mass Adjustments-Retro Rate	999,999		999,999		999,999		999,999	
56 Mass Adjustments	999,999		999,999		999,999		999,999	
57 Adjs. reprocessed by EDS	999,999		999,999		999,999		999,999	
58 Open	999,999		999,999		999,999		999,999	
59 History Reversals	999,999		999,999		999,999		999,999	
TOTAL	999,999		999,999		999,999		999,999	
SUSPENDED ADJUSTMENTS BY LOCATION								
00 Validity	999,999		999,999		999,999		999,999	
01 Provider	999,999		999,999		999,999		999,999	
02 Recipient	999,999		999,999		999,999		999,999	
03 PA	999,999		999,999		999,999		999,999	
04 Procedure Code	999,999		999,999		999,999		999,999	
20 History	999,999		999,999		999,999		999,999	
21 Medical Policy	999,999		999,999		999,999		999,999	
22 Medical Review	999,999		999,999		999,999		999,999	
23 Manual Pricing	999,999		999,999		999,999		999,999	
30 SUR Provider	999,999		999,999		999,999		999,999	
31 SUR Recipient	999,999		999,999		999,999		999,999	
40 CCF	999,999		999,999		999,999		999,999	
41 Recycle	999,999		999,999		999,999		999,999	
42 Hold	999,999		999,999		999,999		999,999	
43 IFSSA	999,999		999,999		999,999		999,999	
44 CSHCS	999,999		999,999		999,999		999,999	
Total	999,999		999,999		999,999		999,999	

OUTPATIENT	BEGINNING		NEW		PROCESSED		ENDING	
	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS
CLAIMS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
SUSPENDED CLAIMS BY LOCATION								
00 Validity	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
04 Procedure Code	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
21 Medical Policy	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
22 Medical Review	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
23 Manual Pricing	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
NEW ADJUSTMENTS BY REGION								
45 Converted Adjustments	999,999		999,999		999,999		999,999	
46 Converted 590 Adjustments	999,999		999,999		999,999		999,999	
50 Non-check related Adjustments	999,999		999,999		999,999		999,999	
51 Check related Adjustments	999,999		999,999		999,999		999,999	
54 Mass Adjustments-Void txns	999,999		999,999		999,999		999,999	
55 Mass Adjustments-Retro Rate	999,999		999,999		999,999		999,999	
56 Mass Adjustments	999,999		999,999		999,999		999,999	
57 Adjs. reprocessed by EDS	999,999		999,999		999,999		999,999	
58 Open	999,999		999,999		999,999		999,999	
59 History Reversals	999,999		999,999		999,999		999,999	
TOTAL	999,999		999,999		999,999		999,999	
SUSPENDED ADJUSTMENTS BY LOCATION								
00 Validity	999,999		999,999		999,999		999,999	
01 Provider	999,999		999,999		999,999		999,999	
02 Recipient	999,999		999,999		999,999		999,999	
03 PA	999,999		999,999		999,999		999,999	
04 Procedure Code	999,999		999,999		999,999		999,999	
20 History	999,999		999,999		999,999		999,999	
21 Medical Policy	999,999		999,999		999,999		999,999	
22 Medical Review	999,999		999,999		999,999		999,999	
23 Manual Pricing	999,999		999,999		999,999		999,999	
30 SUR Provider	999,999		999,999		999,999		999,999	
31 SUR Recipient	999,999		999,999		999,999		999,999	
40 CCF	999,999		999,999		999,999		999,999	
41 Recycle	999,999		999,999		999,999		999,999	
42 Hold	999,999		999,999		999,999		999,999	
43 IFSSA	999,999		999,999		999,999		999,999	
44 CSHCS	999,999		999,999		999,999		999,999	
Total	999,999		999,999		999,999		999,999	

MEDICAL	BEGINNING		NEW		PROCESSED		ENDING	
	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS
CLAIMS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
SUSPENDED CLAIMS BY LOCATION								
00 Validity	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
04 Procedure Code	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
21 Medical Policy	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
22 Medical Review	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
23 Manual Pricing	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
NEW ADJUSTMENTS BY REGION								
45 Converted Adjustments	999,999		999,999		999,999		999,999	
46 Converted 590 Adjustments	999,999		999,999		999,999		999,999	
50 Non-check related Adjustments	999,999		999,999		999,999		999,999	
51 Check related Adjustments	999,999		999,999		999,999		999,999	
54 Mass Adjustments-Void txns	999,999		999,999		999,999		999,999	
55 Mass Adjustments-Retro Rate	999,999		999,999		999,999		999,999	
56 Mass Adjustments	999,999		999,999		999,999		999,999	
57 Adjs. reprocessed by EDS	999,999		999,999		999,999		999,999	
58 Open	999,999		999,999		999,999		999,999	
59 History Reversals	999,999		999,999		999,999		999,999	
TOTAL	999,999		999,999		999,999		999,999	
SUSPENDED ADJUSTMENTS BY LOCATION								
00 Validity	999,999		999,999		999,999		999,999	
01 Provider	999,999		999,999		999,999		999,999	
02 Recipient	999,999		999,999		999,999		999,999	
03 PA	999,999		999,999		999,999		999,999	
04 Procedure Code	999,999		999,999		999,999		999,999	
20 History	999,999		999,999		999,999		999,999	
21 Medical Policy	999,999		999,999		999,999		999,999	
22 Medical Review	999,999		999,999		999,999		999,999	
23 Manual Pricing	999,999		999,999		999,999		999,999	
30 SUR Provider	999,999		999,999		999,999		999,999	
31 SUR Recipient	999,999		999,999		999,999		999,999	
40 CCF	999,999		999,999		999,999		999,999	
41 Recycle	999,999		999,999		999,999		999,999	
42 Hold	999,999		999,999		999,999		999,999	
43 IFSSA	999,999		999,999		999,999		999,999	
44 CSHCS	999,999		999,999		999,999		999,999	
Total	999,999		999,999		999,999		999,999	

DENTAL	BEGINNING		NEW		PROCESSED		ENDING	
	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS
CLAIMS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
SUSPENDED CLAIMS BY LOCATION								
00 Validity	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
04 Procedure Code	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
21 Medical Policy	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
22 Medical Review	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
23 Manual Pricing	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
NEW ADJUSTMENTS BY REGION								
45 Converted Adjustments	999,999		999,999		999,999		999,999	
46 Converted 590 Adjustments	999,999		999,999		999,999		999,999	
50 Non-check related Adjustments	999,999		999,999		999,999		999,999	
51 Check related Adjustments	999,999		999,999		999,999		999,999	
54 Mass Adjustments-Void txns	999,999		999,999		999,999		999,999	
55 Mass Adjustments-Retro Rate	999,999		999,999		999,999		999,999	
56 Mass Adjustments	999,999		999,999		999,999		999,999	
57 Adjs. reprocessed by EDS	999,999		999,999		999,999		999,999	
58 Open	999,999		999,999		999,999		999,999	
59 History Reversals	999,999		999,999		999,999		999,999	
TOTAL	999,999		999,999		999,999		999,999	
SUSPENDED ADJUSTMENTS BY LOCATION								
00 Validity	999,999		999,999		999,999		999,999	
01 Provider	999,999		999,999		999,999		999,999	
02 Recipient	999,999		999,999		999,999		999,999	
03 PA	999,999		999,999		999,999		999,999	
04 Procedure Code	999,999		999,999		999,999		999,999	
20 History	999,999		999,999		999,999		999,999	
21 Medical Policy	999,999		999,999		999,999		999,999	
22 Medical Review	999,999		999,999		999,999		999,999	
23 Manual Pricing	999,999		999,999		999,999		999,999	
30 SUR Provider	999,999		999,999		999,999		999,999	
31 SUR Recipient	999,999		999,999		999,999		999,999	
40 CCF	999,999		999,999		999,999		999,999	
41 Recycle	999,999		999,999		999,999		999,999	
42 Hold	999,999		999,999		999,999		999,999	
43 IFSSA	999,999		999,999		999,999		999,999	
44 CSHCS	999,999		999,999		999,999		999,999	
Total	999,999		999,999		999,999		999,999	

PHARMACY	BEGINNING		NEW		PROCESSED		ENDING	
	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS	PAPER	POS/ECS
CLAIMS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
SUSPENDED CLAIMS BY LOCATION								
00 Validity	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
01 Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
02 Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
03 PA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
04 Procedure Code	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
20 History	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
21 Medical Policy	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
22 Medical Review	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
23 Manual Pricing	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
30 SUR Provider	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
31 SUR Recipient	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
40 CCF	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
41 Recycle	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
42 Hold	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
43 IFSSA	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
44 CSHCS	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
Total	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999
NEW ADJUSTMENTS BY REGION								
45 Converted Adjustments	999,999		999,999		999,999		999,999	
46 Converted 590 Adjustments	999,999		999,999		999,999		999,999	
50 Non-check related Adjustments	999,999		999,999		999,999		999,999	
51 Check related Adjustments	999,999		999,999		999,999		999,999	
54 Mass Adjustments-Void txns	999,999		999,999		999,999		999,999	
55 Mass Adjustments-Retro Rate	999,999		999,999		999,999		999,999	
56 Mass Adjustments	999,999		999,999		999,999		999,999	
57 Adjs. reprocessed by EDS	999,999		999,999		999,999		999,999	
58 Open	999,999		999,999		999,999		999,999	
59 History Reversals	999,999		999,999		999,999		999,999	
TOTAL	999,999		999,999		999,999		999,999	
SUSPENDED ADJUSTMENTS BY LOCATION								
00 Validity	999,999		999,999		999,999		999,999	
01 Provider	999,999		999,999		999,999		999,999	
02 Recipient	999,999		999,999		999,999		999,999	
03 PA	999,999		999,999		999,999		999,999	
04 Procedure Code	999,999		999,999		999,999		999,999	
20 History	999,999		999,999		999,999		999,999	
21 Medical Policy	999,999		999,999		999,999		999,999	
22 Medical Review	999,999		999,999		999,999		999,999	
23 Manual Pricing	999,999		999,999		999,999		999,999	
30 SUR Provider	999,999		999,999		999,999		999,999	
31 SUR Recipient	999,999		999,999		999,999		999,999	
40 CCF	999,999		999,999		999,999		999,999	
41 Recycle	999,999		999,999		999,999		999,999	
42 Hold	999,999		999,999		999,999		999,999	
43 IFSSA	999,999		999,999		999,999		999,999	
44 CSHCS	999,999		999,999		999,999		999,999	
Total	999,999		999,999		999,999		999,999	

End of Report

Section 8: CPA Reports

CPA-0001-M CPAS Sample Listing

Functional Area	Report Number	Job Name	Report Title
CPAS	CPA-0001-M		CPAS Sample Listing

Description of Information

The CPAS Sample Listing provides basic information about the claims selected by the sample routine.

Purpose

IFSSA and EDS use the CPAS Sample Listing to review the claims selected in the sample prior to generating the detail data sheets for each claim. This report allows the user to verify that the sample is of adequate size and scope to successfully perform the review.

Sort Sequence

- *Primary -* Order selected, with page break between claim stratums.

Distribution

To	Media	Copies	Frequency
IFSSA	Paper	1	Monthly
EDS	Paper	1	Monthly

Detailed Field Definitions

Sequence Number	The order of the claim within the sample. For example, the first claim selected in the sample has a sequence number of 001.
Selection Number	The order of the claim within the sample universe. For example, if the first claim in the sample was the 9,651st record on the claims history database, the selection number would be 9,651.
ICN	The internal control number assigned to the sample claim
Provider Number/Location	The billing provider number and location code from the sample claim
RID	The recipient identification number from the sample claim
From Date of Service	The start date of service from the sample claim, in MM/DD/CCYY format
To Date of Service	The end date of service from the sample claim, in MM/DD/CCYY format

Allowed Amount	The total allowed amount for the service(s) on the sample claim prior to deducting patient liability, spenddown, TPL, or any co-payments
Paid Amount	The total amount reimbursed to the provider for the service(s) billed on the sample claim
Paid Date	The date the sample claim reached final adjudication in MM/DD/CCYY format
Summary Information	For each stratum, the following summary information is reported
Claims in Sample Universe	The total number of claims in the sampling universe for the stratum
Selected Claims	The number of claims selected from the universe of history claims for the stratum
Allowed Amount For Sample Universe	The total amount allowed for the services in the stratum prior to deducting patient liability, spenddown, TPL, or any co-payments
Allowed Amount For Selected Claims	The total amount allowed for the services on the selected claims prior to deducting patient liability, spenddown, TPL, or any co-payments
Paid Amount For Sample Universe	The total benefit dollars paid by the program for claims in the stratum
Paid Amount For Selected Claims	The total benefit dollars paid out by the program for claims selected for the sample
Grand Total Information	Report the following grand total information combining the summary information from each stratum
Claims In Sample Universe	The total number of claims in the sampling universe
Selected Claims	The number of claims selected from the universe of history claims for the sample
Allowed Amount For Sample Universe	The total amount allowed for the services in the sample universe prior to deducting patient liability, spenddown, TPL, or any co-payments
Allowed Amount For Selected Claims	The total amount allowed for the services on the selected claims prior to deducting patient liability, spenddown, TPL, or any co-payments
Paid Amount For Sample Universe	The total benefit dollars paid out by the program for claims in the sampling universe
Paid Amount For Selected Claims	The total benefit dollars paid out by the program for claims selected for the sample
Report Footer	The report footer displays **End of Report**, after the grand total information listed, and **No Data This Report** if no claims are selected based on the sampling criteria requested

Report: CPA-0001-M IndianaAIM Run Date: 07/28/1999
Process: CPAJM001 Run Time: 21:19:57
Location: CPA0001M CPAS Sample Listing Report Page: 1

Strata Name: Outpatient

Sequence Number	Selection Number	ICN	Provider Number/ Location	RID	From Date of Service	To Date of Service	Allowed Amount	Paid Amount	Paid Date
1	204	2099 147 132541	100269230 A	101941589099	05/05/1999	05/05/1999	97.00	97.00	07/06/1999
2	2651	2099 165 132806	100268120 A	100009996899	05/13/1999	05/13/1999	3.63	3.63	06/14/1999
3	5098	2099 166 132148	100269230 A	100289016699	03/02/1999	03/02/1999	21.82	21.82	06/15/1999
4	7545	2099 167 132342	100268340 A	100357730999	05/28/1999	05/28/1999	28.06	28.06	06/16/1999
5	9992	2099 168 131967	100268850 A	101883856399	06/07/1999	06/07/1999	77.57	77.57	06/17/1999
6	12439	1199 148 134380	100270430 A	100041232899	04/12/1999	04/26/1999	22.08	22.08	06/23/1999
7	14886	1099 153 132310	100268730 A	100414399499	05/20/1999	05/20/1999	205.60	205.60	06/21/1999
8	17333	2099 173 131788	100385760 A	102598758599	06/07/1999	06/07/1999	67.92	67.92	06/22/1999
29	68720	2099 202 132362	100270200 A	102614569699	07/16/1999	07/16/1999	125.12	125.12	07/21/1999
30	71167	2099 203 132297	100269800 A	102646858599	06/14/1999	06/14/1999	134.33	134.33	07/22/1999

Summary Information:

	Number of Claims	Allowed Amount	Paid Amount
Sample Universe:	73,418	9,321,614.38	9,065,596.16
Selected Claims:	30	3,354.51	3,329.76

Grand Total Information:

	Number of Claims	Allowed Amount	Paid Amount
Sample Universe:	19,574	35,661,438.33	35,049,675.82
Selected Claims:	106	33,785.80	33,360.13

End of Report

CPA-0010-M Claim Data Sheets - Pharmacy,

CPA-0011-M Claim Data Sheets - Dental,

CPA-0012-M Claim Data Sheets – CMS-1500,

CPA-0013-M Claim Data Sheets – UB-92

Functional Area	Report Number	Job Name	Report Title
CPAS	CPA-0013-M CPA-0010-M CPA-0011-M CPA-0012-M	CPAJM010	Claim Data Sheets

Description of Information

The Claim Data Sheets contains all fields in the history database for the sample claim along with an audit trail of the claim suspense locations as it progressed through the Indiana*AIM* system. The format of the data sheets is specifically designed for each claim type; therefore the format varies from claim type to claim type.

Purpose

IFSSA and EDS use the Claim Data Sheets to perform the federally required CPAS reviews in the Indiana*AIM* system.

Sort Sequence

- *Primary* - Claim stratum
- *Secondary* - Claim type
- *Tertiary* - Billing provider number
- *Quaternary* - Recipient identification number (RID)
- *Quintenary* - Internal control number (ICN)

Distribution

To	Media	Copies	Frequency
IFSSA	Paper	1	Monthly
EDS	Paper	1	Monthly

Detailed Field Definitions – CPA-0013-M Claim Data Sheets - UB-92

ICN	The internal control number assigned to the claim by the Indiana*AIM* system
Claim Type	The program under which the claim was filed. Valid values: Inpatient Crossover A Outpatient Crossover C Home Health Long Term Care
ICN Date	The date the claim was received by the Indiana*AIM* system in MM/DD/CCYY format
Adjudication Date	The date the claim finalized in the Indiana*AIM* system in MM/DD/CCYY format
Status	The final status (paid, denied, or refunded) of the claim in the Indiana*AIM* system
Claim Header Information:	
Admission Date	The admission date
Admission Hour	The admission time
Admission Type	The type of admission
From Date Of Service	The date the service starts
To Date Of Service	The date the services ended
Days Covered	The number of days covered
Type Of Bill	The type of bill
Patient Status	The indicator showing whether the prescription was dispensed as a regular or compound drug
Patient Account No.	The reason code explaining why a name brand drug was dispensed rather than a generic drug
Signature	**Yes** indicates the provider signature was verified at the time of data entry for claims filed on paper
Admission Diagnosis	Admission diagnosis code
Description	Admission diagnosis description
Emergency Diagnosis	The emergency diagnosis code
Description	The emergency diagnosis description

Primary Diagnosis	The primary diagnosis code
Description	The primary diagnosis description
Secondary Diagnosis	The secondary diagnosis code
Description	The secondary diagnosis description
Secondary Diagnosis	The secondary diagnosis code
Description	The secondary diagnosis description
Condition Codes	Any condition codes or **None**
Value Codes	Up to 12 possible value codes submitted on the claim along with the associated dollar amounts
Occurrence Codes	Up to ten possible occurrence codes submitted on the claim along with the associated dates
Surgery Code 1	The surgery code
Date	The date of service for the surgery code
Description	The surgery code description
Surgery Code 2	A surgery code
Date	The date of service for the surgery code
Description	The Surgery Code Description
Date Billed	The date the provider billed the Indiana*AIM* system for the claim in MM/DD/CCYY format
Billed Amount	The total billed amount on the claim
Disp Share Amount	The amount of disproportionate share claimed by the facility
Reimbursement Amount	The amount of reimbursement due back to the provider
Patient Deduct Amount	The amount paid by the patient on the claim
Payer A Code	Payer A amount
Payer B Code	Payer B amount
Payer C Code	Payer C amount
Total Reimb Amount	Total Amount Reimbursed
Claim Detail Information:	
Detail Number	The claim detail sequence number
Detail Status	The detail status

Rev Code	The revenue code
Revenue Description	The revenue description
Proc Code	The procedure code
Procedure Description	The procedure description
Date Of Service	The date of service
Units	The number of units
Allowed Units	The allowed units
Billed Amount	The billed amount
Allowed Amount	The allowed amount
DRG Information:	
DRG Code	The DRG code
DRG ALOS	The DRG ALOS (average length of stay)
DRG Base Amt.	The DRG Base Amt.
Capital Cost	The capital cost
Medical Education Cost	The medical education cost
Outlier Cost	The outlier cost
Level of Care	The level of care
Overhead Rate	The overhead rate
Location Information:	
Location Code	The suspense location of the claim
Location Date	The effective date of the suspense location
Time	The effective time of the suspense location
Location Code 2	The suspense location of the claim
Location Date	The effective date of the suspense location
Time	The effective time of the suspense location
Location Code 3	The suspense location of the claim
Location Date	The effective date of the suspense location
Time	The effective time of the suspense location
EOB Information:	

EOB	The four-digit EOB code
Detail Number	The applicable detail number for the EOB code on the claim
EOB Description	The first 30 characters of the EOB message
Error Status Code Information:	
Detail Number	The detail number the ESC applies to on the claim
ESC	The action taken on the error status code (deny or force for example), and the four-digit error status code
ESC Description	The ESC Description field displays the first 30 characters of the error status code description
Detail Number 2	The applicable detail number of the ESC on the claim
ESC	The action taken on the error status code (deny or force), and the four-digit error status code
ESC Description	The first 30 characters of the error status code description
Provider Information:	
Provider Number	The identification number and service location of the billing provider on the claim
Provider Name	The name on file for the billing provider
Type	The code and description for the program under which the provider billed the service
Description	The provider description
Specialty	The provider service specialty code and description under which the claim was processed
Description	The specialty description
Specialty Effective Date	Date specialty became effective
Specialty End Date	Date specialty ends
Eligibility Effective Date	Date program eligibility became effective
Eligibility End Date	Date program eligibility ends
Medical Education Rate	The medical education rate
Cost To Charge Ratio	The cost to charge ratio
Accommodation Rate	The accommodation rate
Level Of Care Rate	The level of care rate
PMP Certification Code	The PMP Certification Code

Effective Date	Date PMP Certification eligibility became effective
End Date	Date PMP Certification eligibility ends
Attn. Provider License	The license number of the attending physician for the service, along with the name and provider type on file for enrolled physicians
Provider Name	The provider name
Type	The provider type
Description	The provider description
Other Provider License 1 Number	The license number of an additional physician associated with the service along with the name and provider type on file for enrolled physicians
Provider Name	The first other provider name
Type	The first other provider type
Description	The first other provider description
Other Provider License 2 Number	The other provider license 2 field will display the license number of a second additional physician associated with the service along with the name and provider type on file for enrolled physicians
Provider Name	The second other provider name
Type	The second other provider type
Description	The second other provider description
Recipient Information:	
Recipient Number	The identification number of the recipient
Name	The name on file for the recipient
Date of Birth	The date of birth on file for the recipient
Age	The recipient's age based on the earliest *from* date of service on the claim record
Health Program	The medical assistance program under which the claim was paid
Patient Liability Amt	The amount of patient liability
TPL Coverage	The TPL coverage
Aid Category	The State aid category under which the claim was processed
Recipient PMP Information:	
PMP ID	The identification number and service location of the recipient’s Primary Medical Physician
Provider Name	The name on file for the recipient’s primary medical physician

Eligibility Effective Date	Date recipient's primary medical physician eligibility became effective
Eligibility End Date	Date recipient's primary medical physician eligibility ends
Group ID	The identification number and service location of the recipient's primary medical physician's group
Group Name	The name on file for the recipient's primary medical physician's group
Eligibility Effective Date	Date recipient's primary medical physician's group eligibility became effective
Eligibility End Date	Date recipient's primary medical physician's group eligibility ends
MCO ID	The identification number and service location of the recipient's MCO
MCO Name	The name on file for the recipient's MCO
Eligibility Effective Date	Date recipient's MCO eligibility became effective
Eligibility End Date	Date recipient's MCO eligibility ends

```
Report: CPA-0013-M                                  IndianaAIM                                  Run Date: 07/28/1999
Process: CPAJM010                                                                                Run Time: 22:23:26
Location: CPA0013M                        Claim Data Sheet (Strata # 2 )                              Page:      1
                                            Strata Name:  Outpatient

Strata Selection Criteria
-------------------------
Strata Name:  Outpatient

Selection Criteria:

                  First Date of Service      Last Date of Service         Location 98 Dates            Amount Paid
Sample Month       From:        Thru:         From:        Thru:          From:        Thru:        From:          To:
--------------   ----------   ----------    ----------   ----------    ----------   ----------    ----------   ----------
June 1999                                                                                             0.00         0.00


Claim Type(s):
--------------
O


Provider Type(s):
--------------
Not specified


Provider Specialty(s):
----------------------
Not specified


Aid Category(s):
----------------
Not specified


Claim Status:
  Paid
```

Report: CPA-0013-M IndianaAIM Run Date:
07/28/1999
Process: CPAJM010 Run Time:
22:23:26
Location: CPA0013M Claim Data Sheet (Strata # 2 / Seq # 1) Page:
2

Strata Name: Outpatient

ICN	Claim Type	ICN Date	Adjudication Date	Status
20 99147 132 541	Outpatient	05/27/1999	07/06/1999	Paid

Claim Header Information:

Admission Date	Admission Hour	Admission Type	From Date of Service	To Date of Service	Days Covered	Type of Bill	Patient Status	Patient Account No.	Signature
	21	3	05/05/1999	05/05/1999	0	131	01	2991106804	

Admission Diagnosis	Description	Emergency Diagnosis	Description	Principal Diagnosis	Description
				78902	ABDOMINAL PAIN,

Secondary Diagnosis	Description	Secondary Diagnosis	Description
V220	SUPERVIS NORMAL 1ST PREG		

Condition Codes: 99 99 99 99 99 99 99

Value Code	Dollar Amount	Value Code	Dollar Amount	Value Code	Dollar Amount	Value Code	Dollar Amount
99	$999,999.99	99	$999,999.99	99	$999,999.99	99	$999,999.99
99	$999,999.99	99	$999,999.99	99	$999,999.99	99	$999,999.99
99	$999,999.99	99	$999,999.99	99	$999,999.99	99	$999,999.99

Occ Code	Date	Occ Code	Date	Occ Code	Date	Occ Code	Date
99	MM/DD/CCYY	99	MM/DD/CCYY	99	MM/DD/CCYY	99	$999,999.99
99	MM/DD/CCYY	99	MM/DD/CCYY	99	MM/DD/CCYY	99	$999,999.99
99	MM/DD/CCYY	99	MM/DD/CCYY				

Surgery Codes	Date	Description	Surgery Codes	Date	Description
7534	05/05/1999	FETAL MONITORING NOS			

Date	Billed Amount	Disp Share Amount	Reimbursement Amount	Patient Deduct Amount	Payer Codes A	B	C	Total Reimb Billed Amount
05/27/1999	$ 213.50	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 213.50	$ 97.00

Claim Detail Information:

Dtl No.	Detail Status	Rev Code	Revenue Description	Proc Code	Procedure Description	Date of Service	Units	Allowed Units	Billed Amount	Allowed Amount
1	P	760	TREATMENT OR OBSER	0	None	05/05/1999	1	1	$ 213.50	$ 97.00

DRG Information:

DRG Code	DRG ALOS	DRG Base Amt.	Capital Cost	Medical Education Cost	Outlier Cost	Level of Care	Overhead Rate

EOB Information:

EOB	Detail Number	Description	EOB	Detail Number	Description
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX

Location Information:

Location	Location Date	Time	Location	Location Date	Time	Location	Location Date Time
40	05/27/1999	16:06:29	98	07/06/1999	17:09:59	99	07/09/1999 24:00:00

ESC Information:

Detail Number	ESC	Description	Detail Number	ESC	Description
1	F 2504	RECIPIENT COVERED BY PRIVATE I			

```
Report: CPA-0013-M                                   IndianaAIM                                   Run Date: 07/28/1999
Process: CPAJM010                                                                                 Run Time: 22:23:29
Location: CPA0013M                      Claim Data Sheet (Strata # 2 / Seq # 1 )                        Page:      3
                                          Strata Name:  Outpatient
```

Provider Information:

Provider Number	Provider Name	Type	Description
100269230 A	MARION GENERAL HOSPITAL	01	Hospital

Specialty	Description	Specialty Effective Date	Specialty End Date	Eligibility Effective Date	Eligibility End Date
010	Acute Care	01/01/1970	12/31/2299	01/01/1970	12/31/2299

Medical Education Rate	Cost to Charge Ratio	Accommodation Rate	Level of Care Rate	PMP Certification Code	Effective Date	End Date
$ 0.00	0.7100%	0.00	0.00			

Attn. Provider

License	Provider Name			Type	Description
01045148	SWAN	SHAWN		31	Physician

Other Provider

License 1 Number	Provider Name			Type	
01030229	LEE	THOMAS	M	31	Physician

Other Provider

License 2 Number	Provider Name			Type	
01045148	LEE	THOMAS	M	31	Physician

Recipient Information:

Recipient Number	Recipient Name	Date of Birth	Age	Health Program	Patient Liability Amt.	TPL Coverage
101941589099	MILLER, TRACEY R	03/26/1980	19	MA-Medicaid	$ 0.00	Yes

Aid Category
N-Pregnant women under 150% FPL

```
 E-Extended eligibility for pregnant women
 2-Children ages 6-19 under 100% FPL
 C-AFDC cash assistance
 10- Hoosier Healthwise-Package C-Childrens Health Plan


                  Recipient PMP Information:
                                                          ------- Eligibility -------
  PMP ID                      Provider Name               Effective Date    End Date
------------       ---------------------------------------  --------------   ----------
100059570  A       MARION GENERAL HOSPITAL                  04/01/1999       12/31/2299

                                                          ------- Eligibility -------
  Group ID                                                Effective Date    End Date
------------                                              --------------   ----------

                                                          ------- Eligibility -------
   MCO ID                                                 Effective Date    End Date
------------                                              --------------   ----------


                                          End of Report
```

Detailed Field Definitions – CPA-0010-M Claim Data Sheets - Pharmacy

ICN	The internal control number assigned to the claim by the Indiana*AIM* system
Claim Type	The program under which the claim was filed Valid value: Pharmacy
ICN Date	The date the claim was received by the Indiana*AIM* system in MM/DD/CCYY format
Adjudication Date	The date the claim was finalized in the Indiana*AIM* system in MM/DD/CCYY format
Status	The final status, for example paid, denied, or refunded, of the claim in the Indiana*AIM* system
Claim Header Information:	
Prescription Number	The prescription number assigned to the claim by the pharmacy
Prescribing License	The medical license number of the medical professional who authorized the prescription
Days Supply	The number of days the prescription meets the requirements of the prescription
Refill Quantity	The number of refills the billing provider has filled on the prescription
Emergency	**Yes** if the prescription is related to an emergency condition, otherwise this field displays **No**
Nursing Home	**Yes** if the prescription was dispensed to a recipient of long term care services, otherwise this field displays **No**
Pregnant	Indicator shows whether the prescription is related to a pregnancy condition
Type	Indicator shows whether the prescription was dispensed as a regular or compound drug
Brand Name Necessary	The reason code explaining why a name brand drug was dispensed rather than a generic drug
Signature	**Yes** indicates the provider signature was verified at the time of data entry for claims filed on paper
Date Prescribed	The date the prescription was written, in MM/DD/CCYY format
Date Dispensed	The date the pharmacy filled the prescription, in MM/DD/CCYY format
Date Billed	The date the provider billed the Indiana*AIM* system for the claim, in MM/DD/CCYY format
Billed Amount	The total billed amount on the claim
TPL Amount	The amount paid by other insurance on the claim

Patient Deductible Amount	The amount of deductible paid by the recipient on the prescription
Co-Pay Amount	The amount of the co-payment made by the recipient on the prescription
Professional Fee	The amount of the dispensing fee paid to the provider
Total Reimbursement Amount	The total amount paid by the Indiana*AIM* system on the claim
Claim Detail Information:	
Detail Number	The claim detail sequence number
NDC	The national drug code for the prescription item
NDC Description	The description on file for the prescription item
Drug Form	The basic measurement unit of the drug
Dispensed Quantity	The units dispensed by the provider in filling the prescription
Billed Amount	The total billed amount for the prescription
Allowed Amount	The total allowed amount for the prescription prior to any reductions, such as TPL or co-pay
AWC	The calculated average wholesale cost for the prescription
EAC	The calculated estimated acquisition cost for the prescription
MAC	The calculated manufacturers acquisition cost for the prescription
EOB Information:	
EOB	The four-digit EOB code
Detail Number	The applicable detail number for the EOB code on the claim
EOB Description	The first 30 characters of the EOB message
Error Status Code Information:	
ESC Status	The action taken on the error status code
ESC	The four-digit error status code
Detail Number	The detail number the ESC applies to on the claim
ESC Description	The first 30 characters of the error status code description
Location Information:	
Location Code	The suspense location of the claim
Location Date	The effective date of the suspense location
Provider Information:	

Provider Number	The identification number and service location of the billing provider on the claim
Provider Name	The name on file for the billing provider
Type	The code and description for the program under which the provider billed the service
Specialty	The provider service specialty code and description under which the claim was processed
Recipient Information:	
Recipient ID	The identification number of the recipient
Name	The name on file for the recipient
Date of Birth	The date of birth on file for the recipient
Age	The recipient's age based on the earliest From date of service on the claim record
Aid Category	The State aid category under which the claim was processed
Health Program	The medical assistance program under which the claim was paid

Report: CPA-0010-M — Indiana*AIM* — Run Date: MM/DD/CCYY
Process: CPAJM010 — Run Time: HH:MM:SS
Location: CPA0010M — Claim Data Sheet — Page Num: 99999
Strata Name: Drug

ICN	Claim Type	ICN Date	Adjudication Date	Status
99 99999 999 999	Pharmacy	MM/DD/CCYY	MM/DD/CCYY	XXXXXXXX

Claim Header Information:

Prescription Number	Prescribing License	Days Supply	Refill Quantity	Type	Emergency	Nursing Home	Pregnancy	Brand Med Necessary	Signature
999999999999	9999999999	999	999	Regular	No	Yes		0	

Billed Amount	TPL Amount	Patient Deductible Amount	Co-Pay Amount	Total Reimbursement Amount	Professional Fee
$ 999.99	$ 999.99	$ 999.99	$ 999.99	$ 999.99	$ 999.99

Claim Detail Information:

Dtl No.	NDC	NDC Description	Drug Form	Dispensed Quantity	Billed Amount	Allowed Amount	AWP	EAC	MAC
99	9999999999999999	XXXXXXXXXXXXXXXXXXXX	XXXXX	9999.99	$ 999.99	$ 999.99	99.99999	99.99999	99.99999

Location Information:

Detail Number	ESC	Description	Detail Number	ESC	Description
99	X 9999	XXXXXXXXXXXXXXXXXXXXXX	99	X 9999	XXXXXXXXXXXXXXXXXXXXXX
99	X 9999	XXXXXXXXXXXXXXXXXXXXXX	99	X 9999	XXXXXXXXXXXXXXXXXXXXXX
99	X 9999	XXXXXXXXXXXXXXXXXXXXXX	99	X 9999	XXXXXXXXXXXXXXXXXXXXXX

Provider Information:

Provider Number	Provider Name	Type	Description
999999999 X	XXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXXXXXXXXXXXXXXXX

Specialty	Description	Specialty Effective Date	End Date	Eligibility Effective Date	End Date
XXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	MM/DD/CCYY	MM/DD/CCYY

Recipient Information:

Recipient Number	Recipient Name	Date of Birth	Age	Health Program
999999999999	XXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	999	XX-XXXXXXXX

Aid Category
A-Aged
D-Disabled
L-Qualified Medicare Beneficiary (QMB)

Detailed Field Definitions – CPA-0011-M Claim Data Sheets - Dental

ICN	The internal control number assigned to the claim by the Indiana*AIM* system
Claim Type	The program under which the claim was filed. Valid value: Dental
ICN Date	The date the claim was received by the Indiana*AIM* system, in MM/DD/CCYY format
Adjudication Date	The date the claim was finalized in the Indiana*AIM* system in MM/DD/CCYY format
Status	The final status, (paid, denied, or refunded) of the claim in the Indiana*AIM* system
Claim Header Information:	
Place Of Service	The code and description of the setting for the service
Accident	Indicator shows whether the service was the result of an accidental injury
Emergency	**Yes** if the service was the result of an emergency situation
Other Plan	**Yes** if the service may be covered under another health care plan
Signature	**Yes** indicates the provider signature was verified at the time of data entry for claims filed on paper
From Date Of Service	The start date billed, in MM/DD/CCYY format
To Date Of Service	The end date billed, in MM/DD/CCYY format
Date Billed	The date the provider billed the Indiana*AIM* system for the claim, in MM/DD/CCYY format
Billed Amount	The total billed amount on the claim
TPL Amount	The amount paid by other insurance on the claim
Patient Deductible Amount	The amount paid by the patient on the claim
Net Billed Amount	The total billed amount on the claim, minus the TPL and patient deductible amounts
Total Reimbursement Amount	The total amount paid by the Indiana*AIM* system for the claim
Claim Detail Information:	
Detail Number	The claim detail sequence number
Detail Status	The adjudication status of the detail
Tooth Number	The tooth number code and description applicable to the performed procedure
Procedure Code	The procedure code and description for the service performed
Date Of Service	The date the service was performed, in MM/DD/CCYY

Billed Amount	The total billed amount for the service
Allowed Amount	The total amount Medicaid allowed for the service
Pricing Indicator	The code indicating the pricing methodology used to process the claim
Error Status Code Information:	
ESC Status	The action taken on the error status code
ESC	The four-digit error status code
Detail Number	The applicable detail number for the ESC on the claim
ESC Description	The first 30 characters of the error status code description
EOB Information:	
EOB	The four-digit EOB code
Detail Number	The applicable detail number for the EOB code on the claim
EOB Description	The first 30 characters of the EOB message
Location Information:	
Location Code	The suspense location of the claim
Location Date	The effective date of the suspense location
Provider Information:	
Provider Number	The identification number and service location of the billing provider on the claim
Provider Name	The name on file for the billing provider
Type	The code and description for the program under which the provider billed the service
Specialty	The provider service specialty code and description under which the claim was processed
Recipient Information:	
Recipient ID	The identification number of the recipient
Name	The name on file for the recipient
Date Of Birth	The date of birth on file for the recipient
Age	The recipient's age based on the earliest From date of service on the claim record
Aid Category	The State aid category under which the claim was processed
Health Program	The medical assistance program under which the claim was paid

Report: CPA-0011-M Indiana*AIM* Page Num: 99999 of 99999
Process: XXXXXX Run Date: MM/DD/CCYY
Location: XXXXXX Claim Data Sheet

ICN	Claim Type	ICN Date	Adjudication Date	Status
99 99999 999 999	Dental	MM/DD/CCYY	MM/DD/CCYY	XXXXXXXX

Claim Header Information:

Place of Service	Accident	Emergency	Other Plan	Signature
XX	XXXX	XXX	XXX	XXX

From Date of Service	To Date of Service	Date Billed	Billed Amount	TPL Amount	Patient Deductible Amount	Net Billed Amount	Total Reimbursement Amount
MM/DD/CCYY	MM/DD/CCYY	MM/DD/CCYY	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99

Claim Detail Information:

Dtl No.	Dtl Status	Tooth Number	Procedure Code	Procedure Description	Date of Service	Billed Amount	Allowed Amount	Pricing Indicator
99	X	XX	XXXXX	XXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	$999,999.99	$999,999.99	X

ESC Information:

	ESC	Detail Number	Description		ESC	Detail Number	Description
X	9999	99	XXXXXXXXXXXXXXXXXXXXX	X	9999	99	XXXXXXXXXXXXXXXXXXXXX
X	9999	99	XXXXXXXXXXXXXXXXXXXXX	X	9999	99	XXXXXXXXXXXXXXXXXXXXX
X	9999	99	XXXXXXXXXXXXXXXXXXXXX	X	9999	99	XXXXXXXXXXXXXXXXXXXXX

EOB Information:

EOB	Detail Number	Description	EOB	Detail Number	Description
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX

Location Information:

Location	Location Date	Location	Location Date	Location	Location Date
99	MM/DD/CCYY	99	MM/DD/CCYY	99	MM/DD/CCYY
99	MM/DD/CCYY	99	MM/DD/CCYY	99	MM/DD/CCYY
99	MM/DD/CCYY	99	MM/DD/CCYY	99	MM/DD/CCYY

Provider Information:

Provider Number	Provider Name	Type	Description
999999999 X	XXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXXXXXXXXXXXXXXX

Specialty	Description	Effective Date	End Date
XXX	XXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY

Recipient Information:

Recipient Number	Recipient Name	Date of Birth	Age	Aid Category	Health Program
999999999999	XXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	999	XX-XXXXXXXX	XX-XXXXXXXX

Detailed Field Definitions – CPA-0012-M Claim Data Sheets – CMS-1500

ICN	The internal control number assigned to the claim by the Indiana*AIM* system
Claim Type	The program under which the claim was filed. Valid values: CMS-1500 Crossover B
ICN Date	The date the claim was received by the Indiana*AIM* system, in MM/DD/CCYY format
Adjudication Date	The date the claim was finalized in the Indiana*AIM* system, in MM/DD/CCYY format
Status	The final status (paid, denied, or refunded) of the claim in the Indiana*AIM* system.
Claim Header Information:	
From Date Of Service	The start date of service billed, in MM/DD/CCYY format
To Date Of Service	The end date of service billed, in MM/DD/CCYY format
Referring Provider	The ID number of the provider who referred the recipient for treatment
Patient Account Number	The account number assigned to the claim by the provider
Accident	Indicator shows whether the service was the result of an accidental injury
Attachment	**Yes** if the claim was submitted with attached documentation
Certification Number	The code allowing for referred services as part of the managed care program
Signature	**Yes** indicates the provider signature was verified at the time of data entry for claims filed on paper
Diagnosis Codes	Up to four possible diagnosis codes submitted on the claim along with the description of the code
Date Billed	The date the provider billed the Indiana*AIM* system for the claim, in MM/DD/CCYY format
Billed Amount	The total billed amount on the claim
TPL Amount	The amount paid by other insurance for the claim
Patient Deductible Amount	The amount paid by the patient for the claim
Co-Pay Amount	The amount of the co-payment made by the recipient for the service
Net Billed Amount	The total billed amount on the claim, minus the TPL and patient deductible amounts
Total Reimbursement Amount	The total amount paid by the Indiana*AIM* system for the claim
Claim Detail Information:	

Detail Number	The claim detail sequence number
Detail Status	The adjudication status of the detail
From Date Of Service	The start date of treatment, in MM/DD/CCYY format
To Date Of Service	The end date of treatment in MM/DD/CCYY format
Place Of Service	The code and description of the setting for the service
Procedure Code	The procedure code and description for the service performed
Modifiers	Up to three modifier codes billed with the procedure
Diagnosis Xref	The code corresponding with the header diagnosis code for the treatment
Performing Provider	The provider number and service location of the medical professional responsible for rendering the service
Emergency	**Yes** if the service was the result of an emergency situation
EPSDT	Indicator shows whether the service was related to an EPSDT screening
Pregnant	Indicator shows whether the service is related to a pregnancy condition
Units	The number of units of the procedure billed on the detail
Units Allowed	The number of units of the procedure allowed as covered by the Indiana*AIM* system
Billed Amount	The total billed amount for the service
Allowed Amount	The total amount Medicaid allowed for the service
Pricing Indicator	The code indicating the pricing methodology used to process the claim
Error Status Code Information:	
ESC Status	The action taken on the error status code
ESC	The four-digit error status code
Detail Number	The detail number the ESC applies to on the claim
ESC Description	The first 30 characters of the error status code description
EOB Information:	
EOB	The four-digit EOB code
Detail Number	The applicable detail number for the EOB code on the claim
EOB Description	The first 30 characters of the EOB message
Location Information:	
Location Code	The suspense location of the claim

Location Date	The effective date of the suspense location
Provider Information:	
Provider Number	The identification number and service location of the billing provider on the claim
Provider Name	The name on file for the billing provider
Type	The code and description for the program under which the provider billed the service
Specialty	The provider service specialty code and description under which the claim was processed
Recipient Information:	
Recipient ID	The identification number of the recipient
Name	The name on file for the recipient
Date Of Birth	The date of birth on file for the recipient
Age	The recipient's age based on the earliest From date of service on the claim record
Aid Category	The State aid category under which the claim was processed
Health Program	The medical assistance program under which the claim was paid

Report: CPA-0012-M Indiana*AIM* Page Num: 99999 of 99999
Process: XXXXXX Run Date: MM/DD/CCYY
Location: XXXXXX

Claim Data Sheet

ICN	Claim Type	ICN Date	Adjudication Date	Status
99 99999 999 999	HCFA-1500	MM/DD/CCYY	MM/DD/CCYY	XXXXXXXX

Claim Header Information:

From Date of Service	To Date of Service	Referring Provider	Patient Account No.	Accident	Attachment	Certification Number	Signature
MM/DD/CCYY	MM/DD/CCYY	999999999	XXXXX	XXX	XXX	XXX	XXX

Diagnosis	Description	Diagnosis	Description
XXXXX	XXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXX
XXXXX	XXXXXXXXXXXXXXXXXXXXX	XXXXX	XXXXXXXXXXXXXXXXXXXXX

Date Billed	Billed Amount	TPL Amount	Patient Deductible Amount	Co-Payment Amount	Net Billed Amount	Total Reimbursement Amount
MM/DD/CCYY	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99	$999,999.99

Claim Detail Information:

Dtl No.	Dtl Status	From Date of Service	To Date of Service	Place of Service	Procedure Code	Procedure Description	Modifiers	Diagnosis XRef
99	X	MM/DD/CCYY	MM/DD/CCYY	XX	XXXXX	XXXXXXXXXXXXXXXXXXXX	XX XX XX	XXXXX

Performing Provider		Emergency	EPSDT	Pregnant	Units	Allowed Units	Billed Amount	Allowed Amount	Pricing Indicator
999999999	X	XXX	X	XXX	99999	99999	$999,999.99	$999,999.99	X

ESC Information:

	ESC	Detail Number	Description		ESC	Detail Number	Description
X	9999	99	XXXXXXXXXXXXXXXXXXXXX	X	9999	99	XXXXXXXXXXXXXXXXXXXXX
X	9999	99	XXXXXXXXXXXXXXXXXXXXX	X	9999	99	XXXXXXXXXXXXXXXXXXXXX
X	9999	99	XXXXXXXXXXXXXXXXXXXXX	X	9999	99	XXXXXXXXXXXXXXXXXXXXX

EOB Information:

EOB	Detail Number	Description	EOB	Detail Number	Description
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX
9999	99	XXXXXXXXXXXXXXXXXXXXX	9999	99	XXXXXXXXXXXXXXXXXXXXX

Location Information:

Location	Location Date	Location Time	Location	Location Date	Location	Location Date
99	MM/DD/CCYY	HH:MM:SS	99	MM/DD/CCYY	99	MM/DD/CCYY
99	MM/DD/CCYY	HH:MM:SS	99	MM/DD/CCYY	99	MM/DD/CCYY
99	MM/DD/CCYY	HH:MM:SS	99	MM/DD/CCYY	99	MM/DD/CCYY

Provider Information:

Provider Number	Provider Name	Type	Description
999999999 X	XXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXXXXXXXXXXXXXXX

				---------- Eligibility ----------	
Specialty	Description	Effective Date	End Date	Effective Date	End Date
XXX	XXXXXXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	MM/DD/CCYY	MM/DD/CCYY	MM/DD/CCYY

PMP Provider's Eligibility

Effective Date	End Date
MM/DD/CCYY	MM/DD/CCYY

Recipient Information:

Recipient Number	Recipient Name	Date of Birth	Age	Health Program	TPL Coverage	Medicare Coverage
999999999999	XXXXXXXXXXXXXXXXXXXXX	MM/DD/CCYY	999	XX-XXXXXXXX	No	A,B

Aid Category
XX-XXXXXXXX

PMP ID		Provider Name	------- Eligibility ------- Effective Date	End Date
100059570	A	MARION GENERAL HOSPITAL	04/01/1999	12/31/2299

Group ID	------- Eligibility ------- Effective Date	End Date
	04/01/1999	12/31/2299

MCO ID	------- Eligibility ------- Effective Date	End Date
	04/01/1999	12/31/2299

Section 9: CTL Reports

CTL-0007-R Claims in Process

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0007-R		Claims In Process

***This report is currently in SME review. 12/27/00*

CTL-0100-D Daily POS Transaction Detail Report

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0100-D		Daily POS Transaction Detail Report

Description of Information on the Report

The CTL-0100-D Daily POS (Point of Service) Transaction Detail Report shows the total number of POS transactions accepted and rejected for each transaction type and all transaction types reported. It will also report the amount of time in seconds taken to process a claim.

Purpose of Report

The Daily POS Transaction Detail Report is used by EDS to monitor POS performance and transmission volume.

Sort Sequence

- *Primary* - Transaction type
- *Secondary* - Provider number

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	3	Daily

Detailed Field Definitions

Prov Num — A system assigned number used to uniquely identify a provider

Type — The type of the POS transaction. Valid types include:

Elig – Eligibility/EVS
Drug – Drug claim
CMS – CMS 1500 claim
Inpt – Inpatient claim
Outp – Outpatient claim
HomH – Home Health claim
NurH – Nursing Home claim
Dent – Dental claim
Revs – Reversal

Txns Accepted — The number of transactions accepted for this provider

Txns Rejected — The number of transactions rejected for this provider

Total Txns — The total number of accepted and rejected transactions for this provider

Total	Total number of POS transactions for this transaction type broken down by transactions accepted, rejected, and the combined total of both accepted and rejected transactions, and claim count totals by *seconds taken to process* for this transaction type. When transaction type has no data, print zeros in columns 2 through 15
Grand Total	The number of POS transactions accepted, rejected, and the combined total of both accepted and rejected transactions, and claim count totals by *seconds taken to process* for all transaction types

Report: CTL-0100-D Indiana*AIM* RunDate: CCYY/MM/DD
Process: Page No.: 99,999
Location

DAILY POS TRANSACTION DETAIL REPORT

TYPE	PROVIDER NUM	TXNS ACCEPTED	TXNS REJECTED	TOTAL TXNS	0-5 SEC	6-10 SEC	11-15 SEC	16-20 SEC	21-25 SEC	26-30 SEC	31-35 SEC	26-40 SEC	41-45 SEC	>45 SEC
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	TOTAL	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	TOTAL	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	999999999	9999	9999	9999										
XXXX	TOTAL	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999
	GRAND TOTAL	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999	99999

CTL-0105-W Claim Batches Activated

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0105-W		Claim Batches Activated

Description of Information

The *Claim Batches Activated Report* displays all activation records transmitted to the system that allow for the claims to be processed. The activations displayed on this report are only for paper claims since electronic claims have an automatic activation generated for them when they are processed. This report is accessible online daily, but a paper copy is printed weekly.

Purpose

The *Claim Batches Activated Report* is used by the Data Entry Supervisor to identify inventory by claim type. The parameter of time is a changeable variable, so that the report can be generated daily, weekly, and monthly.

Sort Sequence

- *Primary* - Activation date
- *Secondary* - Claim type
- *Tertiary* - ICN

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly

Detailed Field Definitions

CT

The one byte field representing claim type. Valid values:

D – Dental
H – Home Health
L – Long Term Care
M – CMS-1500
I – Inpatient
O – Outpatient
P – Pharmacy
X – Crossover A, B, and C

ICN Ranges

The internal control number in RRCCYYJJJBBBSSS format:

R – Region
C – Century
Y – Year
J – Julian Date
B – Batch
S – Sequence

Clerk ID	The three-byte clerk identification number
Date Activated	Date the activation was keyed
# Of Claims	The six-character numeric field representing the total number of claims for each batch range
Summary	The six-character numeric field representing the number of claims per day for each category: Dental, Home Health, Long Term Care, Medical, Inpatient, Outpatient, Pharmacy, Crossover, and for all claim types combined.
Total	The six-character numeric field representing the total of all claim batches activated per week for each claim type and for all claim types combined.

Report: CTL-0105-W **Indiana*AIM*** DATE: CCYYMMDD
Process: PAGE: 99,999
Location:

CLAIM BATCHES ACTIVATED

CT	ICN RANGES	ID	DATE ACTIVATED	# OF CLAIMS
X	RRYYJJJBBBSSS - BBBSSS	X99	MMDDYY	999999
X	RRYYJJJBBBSSS - BBBSSS	X99	MMDDYY	999999
X	RRYYJJJBBBSSS - BBBSSS	X99	MMDDYY	999999

SUMMARY

DATE ACTIVATED	TOTAL	DENT	HME H	LT CARE	MED	INP	OUTP	PHARM	XOVER
MMDDYY	999999	999999	99999	99999	999999	999999	99999	999999	99999
MMDDYY	999999	999999	99999	99999	999999	999999	99999	999999	99999
MMDDYY	999999	999999	99999	99999	999999	999999	99999	999999	99999
MMDDYY	999999	999999	99999	99999	999999	999999	99999	999999	99999
MMDDYY	999999	999999	99999	99999	999999	999999	99999	999999	99999
TOTAL	999999	999999	99999	99999	999999	999999	99999	999999	99999

END OF REPORT

CTL-0110-D Data Entry Inventory

Functional Area	Report Number	Job Name	Report Title
Data Entry	CTL-0110-D		Data Entry Inventory

Description of Information

The report shows data entry inventory, such as paper claims to be keyed, by claim type. Data entry inventory is calculated by starting with the previous day's beginning inventory, adding the previous day's activations and inactive claims keyed, then subtracting the previous day's claims keyed and claims deleted, to arrive at the current days beginning inventory. These claims will only include the inventory for paper claims.

Purpose

EDS and IFSSA use the CTL-0110-D report to monitor data entry inventory and activity on a daily basis. The data entry supervisor uses these numbers to schedule work for the data entry staff.

Sort Sequence

- *Primary -* Claim type

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Daily

Detailed Field Definitions

Beginning Inventory	Number of paper claims to be keyed by data entry staff at the start of the shift
Claims Activated	Paper claims received, ICNs assigned, and activated. This number adds to the inventory of claims to be keyed. Claims are activated in batches.
Inactive Claims Keyed	Claims keyed without first being activated (activating fewer ICNs than necessary for a batch of paper claims is under-activation). This number adds to the inventory of claims activated and claims keyed equally.
Total Receipts	Claims activated, plus inactive claims keyed, equals total receipts
Claims Keyed	Number of claims keyed by Data Entry staff for the shift. Claims keyed are selected from the activated claims inventory and from the inactive claim inventory.
Claims Deleted	Claims deleted due to over-activation. This number decreases the number of claims to be keyed.
Total Processed	Claims keyed, plus claims deleted, equals total processed.
Ending Inventory	Beginning inventory, plus total receipts, minus total processed, equals ending inventory.

Report: CTL-0110-D **Indiana*AIM*** DATE: CCYYMMDD
Process: **DATA ENTRY INVENTORY** PAGE:99,999
Location:

CT	DESC	BEGINNING INVENTORY	CLAIMS ACTIVATED	INACTIVE CLAIMS KEYED	TOTAL RECEIPTS	CLAIMS KEYED	CLAIMS DELETED	TOTAL PROCESSED	ENDING INVENTORY
D	DENTAL	99999	99999	99999	99999	99999	99999	99999	99999
E	SHADOW	99999	99999	99999	99999	99999	99999	99999	99999
H	HOME HEALTH	99999	99999	99999	99999	99999	99999	99999	99999
L	LONG TERM CARE	99999	99999	99999	99999	99999	99999	99999	99999
M	HCFA 1500	99999	99999	99999	99999	99999	99999	99999	99999
I	INPATIENT	99999	99999	99999	99999	99999	99999	99999	99999
O	OUTPATIENT	99999	99999	99999	99999	99999	99999	99999	99999
P	PHARMACY	99999	99999	99999	99999	99999	99999	99999	99999
X	CROSSOVER	99999	99999	99999	99999	99999	99999	99999	99999
	TOTALS	999999	999999	999999	999999	999999	999999	999999	999999

CTL-0120-W ICN Deleted from Control File

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0120-W		ICN Deleted from Control File

Description of Information

All ICNs entered are verified daily by the Data Entry Supervisor. If an ICN was entered for one or more claims that do not exist, those ICNs must be deleted from the activation table and those deletions are on this report. In addition, any claims voided in the Viking system must be deleted from the online tables. Deletions of voids or over-activations must be done daily. The report itself lists the beginning and ending ICNs inappropriately activated, or claims voided in Viking.

Purpose

EDS uses the *ICN Delete from Control File* to monitor all internal control numbers deleted from the control file.

Sort Sequence

- *Primary -* ICN, ascending

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Weekly

Detailed Field Definitions

CT — The one-byte field representing claim type. Valid values:
A – UB-92 inst. crossover
B – Medical crossovers
C – Outp. inst crossovers
D – Dental
H – Home health
I – Inpatient
L – Long term care
M –Medical
O – Outpatient
P – Pharmacy
Q – Compound drug

Beg ICN — Beginning ICN in the range of claim ICNs deleted from the activation file

End ICN — Ending ICN in the range of claim ICNs deleted from the activation file

Clerk — Seven-byte clerk ID of the person who typed the claim

Activation Date — Date the deleted ICN was typed in CCYYMMDD format

Age — Three-byte age of the claim calculated by subtracting the activation date from the current date

```
Report:  CTL-0120-W                          IndianaAIM                          DATE:  CCYYMMDD
Process: CTLJW120                  ICN DELETED FROM CONTROL FILE                   PAGE: 99,999
Location:CTL0120W                Period:  MM/DD/CCYY - MM/DD/CCYY
```

CT	BEG ICN	END ICN	CLERK	ACTIVATION DATE	AGE
X	RRYYJJJBBBSSS	RRYYJJJBBBSSS	XXX	MMDDYY	999
X	RRYYJJJBBBSSS	RRYYJJJBBBSSS	XXX	MMDDYY	999
X	RRYYJJJBBBSSS	RRYYJJJBBBSSS	XXX	MMDDYY	999

END OF REPORT

CTL-0125-W Missing Claim Report

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0125-W		Missing Claim Report

Description of Information

This report lists any individual ICN missing from a batch that has been entered. This report is used to ensure that all claims are accounted for. The main reason that an ICN appears as missing is the over-activation of a batch or a batch transmitted for processing prior to being completely entered. The only way an ICN can be removed from this report is by typing in or deleting the activation.

Purpose

EDS uses the *Missing Claim Report* to monitor individual ICNs activated but not entered into the system. The ICNs listed belong to batches already entered.

Sort Sequence

- *Primary -* ICN, ascending

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Weekly

Detailed Field Definitions

Clerk	Three-byte clerk ID who activated the claim
ICN	Internal control number of the activation that did not have a matching claim entered. ICN format is RRYYJJJBBBSSS. R – Region Y – Year J – Julian Date B – Batch S – Sequence
Activation Date	Date the activation was keyed
Number Of Days	Number of days the missing claim record has been outstanding. Today's Julian date, minus activation Julian date, equals number of days

Report: CTL-0125-W **Indiana*AIM*** DATE:CCYYMMDD
Process: **Missing Claim Report** PAGE: 99,999
Location:

CLERK	ICN	ACTIVATION DATE	NUMBER OF DAYS
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999
XXX	RRYYJJJBBBSSS	MMDDYY	999

END OF REPORT

CTL-0130-D Aged Claims Listing

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0130-D		Aged Claims Listing

Description of Information

The CTL-0130-D Aged Claims report lists aged claims that have not been resolved. The report is sorted by Julian Date. The report displays the current system location of the claim and how long it has been in that location. The report is reviewed daily and all claims listed on the report are given priority during claim resolution. Each claim is researched to determine the cause of the suspense age, and appropriate measures are taken to ensure timely adjudication of the suspended claim. Elapsed days do **not** include time in a Medical Review (22), Recycle (41), Hold (42), IFSSA (43), CHSCS (44), Claim Deny (66), Claim Approved for Payment (98), Claim Paid (99) or CCF (40) location. The excluded locations (except location 22) are not included on this report. The age of the ICN is from the Julian date, less time in excluded locations, less report date. Adjustments are excluded from this report.

Purpose

The Aged Claim Listing report is used by EDS to display all claims **X** days or older currently suspended in the system. This report automatically prints if the claims aging is equal to 25 days or older.

Sort Sequence

- *Primary* - Julian date of ICN
- *Secondary* - Location

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Daily

Detailed Field Definitions

CT	One-byte field representing claim type. Valid values: D – Dental S – Shadow H – Home Health L – Long Term Care M – Medical I – Inpatient O – Outpatient P – Pharmacy X – Crossover A, B and C Q – Compound Drug
ICN	Unique number assigned to a claim processed in the system for internal control purposes. The ICN is in RRCCYYJJJBBBSSS format. Valid Values: R – Region C – Century Y – Year J – Julian date B – Batch S – Sequence
RID	System-assigned number used to identify a unique recipient
Bill Prov	System-assigned number used to identify a unique provider
Elsp Days	Number of days claim was in Indiana*AIM* without being adjudicated. This number excludes the number of days the claim was in a Medical Review (22), Recycle (41), Hold (42), IFSSA (43), CSHCS (44), Adjustments (50), Claim Deny (66), Claim Approved for Payment (98), Claim Paid (99) or CCF (40) location. The excluded locations (except location 22) are not included in this report. The number of days is calculated by subtracting the ICN Julian date from the report date, less the days spent in the excluded locations.
Loc CD	Location code where the claim is currently in suspense.
Loc DT	Date the claim entered location.
Days Loc	Number of claim has been in location. (Current date minus Location date)
Aged Claims Minus Location 22	Total number of claims not adjudicated that are more than **X** days old. This calculation excludes claims aged in location 22.
Claims In Location 22	Total number of claims not adjudicated in location 22 that are **X** days old.
Grand Total	Total number of claims on the report. This is the Aged Claims Minus The Location 22 claims plus Claims In Location 22.

```
       CTL-0130-D                                           IndianaAIM                                      Run Date:  CCYY/MM/DD
       Process:                              TOTAL AGED CLAIMS                                              Page Number:   99,999
       Location
                                                                 AGED CLAIMS LISTING


  CT         ICN               RID          BILL PROV    ELSP DAYS   LOC CD    LOC DT      DAYS LOC

   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       AGED CLAIMS MINUS
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       CLAIMS   IN   LOCATION   22:
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       999999999
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       CLAIMS   IN   LOCATION   22:
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       999999999
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       TOTAL NUMBER OF
   X    9999999999999     999999999999     999999999       999         XX      MMDDYY        999       CLAIMS REPORTED:  9999

                                                                    End of Report
```

CTL-0135-W Aged Active Claim Analysis

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0135-W		Aged Active Claim Analysis

Description of Information

This report lists the number of claims in each age category by claim location. There are six time segments ranging from zero to 91-plus days. Adjustments are excluded from this report.

Purpose

EDS and IFSSA use the *Aged Active Claim Analysis* report to monitor the status of claims in suspense by claim type and establish claim resolution focus. Claims in suspense for long periods of time receive a high priority for resolution. Large groups of claims within a certain suspense location code receive high priority as well. Trends are developed by using this document to track location codes and the age of suspended claims.

Sort Sequence

- *Primary* - Claim type
- *Secondary* - Location code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Weekly

Detailed Field Definitions

Claim Type — One-byte field representing claim type. Valid values:

D – Dental
S – Shadow
H – Home health
L – Long term care
M – CMS-1500
I – Inpatient
O – Outpatient
P – Pharmacy
A – Crossover Part A
B – Crossover Part B (Medical)
C – Crossover (Outpatient)

Desc — Description of claim type indicator

Location Code	15-byte alphanumeric field containing the location of the claim and its two-byte numeric code. Valid values: 00 – Validation 01 – Provider 02 – Recipient 03 – Prior auth 04 – Reference 20 – History 21 – Medical 30 – SURS 40 – CCF 41 – Recycle 42 – Hold 43 – IFSSA 44 – CSCHS 90 – Special handling
Location X Old	Number of claims for these claim types that remained in this location for more than one financial cycle (a one-week period)
Location X Current Bal	Total number of claims suspended in this location
Location X 0-10 Day Count	Total number of claims suspended to this location for 0-10 days
Location X Pct	Percentage of claims suspended to this location. The percentage is determined by the following calculation: Location X 0-10 Day Count ÷ Location X Current Bal
Location X 11-20 Day Count	Total number of claims suspended to this location for 11-20 days
LOCATION X PCT	Percentage of claims suspended to this location. The percentage is determined by the following calculation: Location X 11-20 Day Count ÷ Location X Current Bal
Location X 21-30	Total number of claims suspended to this location for 21-30 days.
Location X Pct	Percentage of claims suspended to this location. The percentage is determined by the following calculation: Location X 21-30 Day Count ÷Location X Current Bal
Location X 31-60 Day Count	Total number of claims suspended to this location for 31-60 days
Location X Pct	Percentage of claims suspended to this location. The percentage is determined by the following calculation: Location X 31-60 Day Count ÷ Location X Current Bal

Location x 61-90 Day Count	Total number of claims suspended to this location for 61-90 days
Location X Pct	Percentage of claims suspended to this location. The percentage is determined by the following calculation: Location X 61-90 Day Count ÷ Location X Current Bal
Location X 91+ Day Count	Total number of claims suspended to this location for 91-plus days
Location X Pct	Percentage of claims suspended to this location. The percentage is determined by the following calculation: Location X 91-plus Day Count ÷ Location X Current Bal
Sub Total Old	Number of claims for these claim types remaining for all locations for more than one financial cycle (a one-week period)
Sub Total New	Number of claims for these claim types new to all locations when the financial cycle ran (less than a one-week period)
Sub Total Average	Average number of days all current suspended claims (both old and new) have been in all locations
Sub Total Current Bal	Total number of claims suspended for all locations in these claim types
Sub Total 0-10 Days	Total number of claims suspended for all locations in these claim types
Sub Total Pct	Percentage of claims suspended for all locations in these claim types. The percentage is determined by the following calculation: 0-10 Day Count ÷ Current Bal
Sub Total 11-20 Days	Total number of claims suspended for all locations for 11-20 days for these claim types
Sub Total Pct	Percentage of claims suspended for all locations in these claim types. The percentage is determined by the following calculation: 11-20 Day Count ÷ Current Bal
Sub Total 21-30 Days	Total number of claims suspended for all locations for 21-30 days for these claim types
Sub Total Pct	Percentage of claims suspended for all locations in these claim types. The percentage is determined by the following calculation: 21-30 Day Count ÷ Current Bal
Sub Total 31-60 Days	Total number of claims suspended for all locations for 31-60 days for these claim types
Sub Total Pct	Percentage of claims suspended for all locations in these claim types. The percentage is determined by the following calculation: 31-60 Day Count ÷ Current Bal
Sub Total 61-90 Days	Total number of claims suspended for all locations for 61-90 days for these claim types

Subtotal Pct	Percentage of claims suspended for all locations in these claim types. The percentage is determined by the following calculation: 61-90 Day Count ÷ Current Bal
Sub Total 91+ Days	Total number of claims suspended for all locations for more than 91 days for these claim types
Subtotal Pct	The percentage of claims suspended for all locations for these claim types. The percentage is determined by the following calculation: All 91-plus Day Count ÷ Current Bal
Sub Total Location X Old	Number of claims for all claim types that remained in this location for more than one financial cycle (a one-week period)
Sub Total Location X New	Number of claims for all claim types new to this location when the financial cycle ran (less than a one-week period)
Sub Total Location X Avg	Average number of days that all current suspended claims (both old and new) have been in this location for all claim types
Sub Total Location X Current Bal	Total number of claims suspended in this location for all claim types
Sub Total Location X 0-10 Day Count	Total number of claims suspended to this location for 0-10 days for all claim types
Sub Total Location X Pct	Percentage of claims suspended to this location for all claim types. The percentage is determined by the following calculation: Location X 0-10 Day Count ÷ Location X Current Bal
Sub Total Location X 11-20 Day Count	Total number of claims suspended to this location for 11-20 days for all claim types
Sub Total Location X Pct	Percentage of claims suspended to this location for all claim types. The percentage is determined by the following calculation: Location X 11-20 Day Count ÷ Location X Current Bal
Sub Total Location X 21-30	Total number of claims suspended to this location for 21-30 days for all claim types
Sub Total Location X Pct	Percentage of claims suspended to this location for all claim types. The percentage is determined by the following calculation: Location X 21-30 Day Count ÷ Location X Current Bal
Sub Total Location X 31-60 Day Count	Total number of claims suspended to this location for 31-60 days for all claim types
Sub Total Location X Pct	Percentage of claims suspended to this location for all claim types. The percentage is determined by the following calculation: Location X 31-60 Day Count ÷ Location X Current Bal Total number of claims suspended to this location for 61–90 days for all claim types
Sub Total Location X Pct	Percentage of claims suspended to this location for all claim types. The percentage is determined by the following calculation: Location X 61-90 Day Count ÷ Location X Current Bal

Sub Total Location X 91+ Day Count	Total number of claims suspended to this location for greater than 91 days for all claim types
Sub Total Location X Pct	Percentage of claims suspended to this location for all claim types. The percentage is determined by the following calculation: Location X 91-plus Day Count ÷ Location X Current Bal
Sub Total Sub Total Old	Number of claims for all claim types that remained for all locations for more than one financial cycle (a one-week period)
Sub Total Sub Total New	Number of claims for all claim types new to all locations when the financial cycle ran (less than a one-week period)
Sub Total Sub Total Average	Average number of days that all current suspended claims (both old and new) have been in all locations for all claim types
Sub Total Sub Total Current Bal	Total number of claims suspended for all locations for all claim types
Sub Total Sub Total 0-10 Days	Total number of claims suspended for all locations for all claim types
Sub Total Sub Total Pct	Percentage of claims suspended for all locations for all claim types. The percentage is determined by the following calculation: 0-10 Day Count ÷ Current Bal
Sub Total Sub Total 11-20 Days	Total number of claims suspended for all locations for 11-20 days for all claim types
Sub Total Sub Total Pct	Percentage of claims suspended for all locations for claim types. The percentage is determined by the following calculation: 11-20 Day Count ÷ Current Bal
Sub Total Sub Total 21-30 Days	Total number of claims suspended for all locations for 21-30 days for all claim types
Sub Total Sub Total Pct	Percentage of claims suspended for all locations for all claim types. The percentage is determined by the following calculation: 21-30 Day Count ÷ Current Bal
Sub Total Sub Total 31-60 Days	Total number of claims suspended for all locations for 31-60 days for all claim types
Sub Total Sub Total Pct	Percentage of claims suspended for all locations for all claim types. The percentage is determined by the following calculation: 31-60 Day Count ÷ Current Bal
Sub Total Sub Total 61-90 Days	Total number of claims suspended for all locations for 61-90 days for all claim types
Sub Total Sub Total Pct	Percentage of claims suspended for all locations for all claim types. The percentage is determined by the following calculation: 61-90 Day Count ÷ Current Bal
Sub Total Sub Total 91+ Days	Total number of claims suspended for all locations for 91-plus days for all claim types

Sub Total Sub Total Pct	Percentage of claims suspended for all locations for all claim types. The percentage is determined by the following calculation: All 91-plus Day Count ÷ Current Bal
Grand Total All Claims	Grand total of all categories by claim type and location code

Report: CTL-0135-W **Indiana*AIM*** DATE: CCYYMMDD
Process: **AGED ACTIVE CLAIM ANALYSIS** PAGE: 99,999
Location:

CLAIM TYPE: X DESC: XXXXXXXXXXXXXXX

LOCATION CODE	CURRENT	0 - 10 DAYS		11 - 20 DAYS		21 - 30 DAYS		31 - 60 DAYS		61 - 90 DAYS		91 + DAYS	
	BAL	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT
00 - VALIDATION	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
01 - PROVIDER	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
02 - RECIPIENT	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
03 - PRIOR AUTH	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
04 - REFERENCE	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
20 - HISTORY	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
21 - MEDICAL	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
30 - SURS	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
40 - CCF	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
41 - RECYCLE	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
42 - HOLD	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
43 - IFSSA	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
44 - CSCHS	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
90 - SPECIAL HANDLIN	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
SUB TOTAL	99999	99999	99.9	99999	99.9	99999	99.9	99999	99.9	99999	99.9	99999	99.9

CLAIM TYPE: X DESC: XXXXXXXXXXXXXXX

LOCATION CODE	CURRENT	0 - 10 DAYS		11 - 20 DAYS		21 - 30 DAYS		31 - 60 DAYS		61 - 90 DAYS		91 + DAYS	
	BAL	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT
00 - VALIDATION	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
01 - PROVIDER	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
02 - RECIPIENT	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
03 - PRIOR AUTH	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
04 - REFERENCE	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
20 - HISTORY	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
21 - MEDICAL	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
30 - SURS	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
40 - CCF	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
41 - RECYCLE	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
42 - HOLD	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
43 - IFSSA	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
44 - CSCHS	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
90 - SPECIAL HANDLIN	9999	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9	9999	99.9
SUB TOTAL	99999	99999	99.9	99999	99.9	99999	99.9	99999	99.9	99999	99.9	99999	99.9
GRAND TOTAL ALL CLAIMS	999999	999999	99.9	999999	99.9	999999	99.9	999999	99.9	999999	99.9	999999	99.9

END OF REPORT

CTL-0140-D Daily Incoming Claim Disposition Summary

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0140-D		Daily Incoming Claim Disposition Summary

Description of Information

The report shows the number of claims received by EDS daily and the disposition of the claims received. Claim disposition is reflected by the claim location assigned to the claim.

Purpose

EDS uses the *Daily Incoming Claim Summary* to control and track claims received. It allows EDS to ensure that each claim received is accounted for.

Sort Sequence

- *Primary* - Claim type
- *Secondary* - Region code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Daily

Detailed Field Definitions

Claim Type — The type of claim form received by EDS. Valid values:

Dental
Pharmacy
CMS-1500
Compound drug
CMS-1500 Xover
CMS-1500
UB-92 Inst Xover
UB-92 Outp Xover
Home Health
Inpatient
Long Term Care
Outpatient
Shadow

10 — Number of paper claims received by EDS without attachments

11 — Number of paper claims received by EDS with attachments

20 — Number of ECS claims received by EDS with no attachment indicators

22	Number of shadow claims received by EDS
23	Number of Crossover claims submitted by providers using the Provider Electronic Solutions software and processed by EDS
25	Number of POS claims received by EDS with no attachment indicators
40	Number of converted MMIS claims processed by EDS
41	Number of converted 590 MMIS claims processed by EDS
45	Number of converted MMIS adjustment claims processed by EDS
46	Number of converted 590 MMIS adjustment claims processed by EDS
50	Number of non-check related adjustments claims processed by EDS
51	Number of check related adjustment claims processed by EDS
54	Number of check voided mass adjustments processed by EDS
55	Number of nursing home adjustment claims processed by EDS
56	Number of financial adjustment claims processed by EDS
57	Number of mass adjustments reprocessed by EDS SEs
70	Number of HMO capitation claims processed by EDS
80	Number of claims reprocessed by EDS SEs
90	Number of special handling claims processed by EDS
TOTAL	Total number of claims received by claim type
LOC 00	Number of claims that failed validation edits
LOC 01	Number of claims that failed provider-related edits
LOC 02	Number of claims that failed recipient-related edits
LOC 03	Number of claims that failed PA-related edits
LOC 04	Number of claims that failed reference file-related edits
LOC 20	Number of claims that failed history-related duplication audits
LOC 21	Number of claims that failed medical policy-related audits
LOC 22	Number of claims that failed medical policy-related audits and require review by medical policy staff
LOC 23	Number of claims that failed for manual pricing
LOC 30	Number of claims that failed utilization review edits
LOC 40	Number of claims that generated CCFs back to providers for correction

LOC 43	Number of claims that failed edits or audits and must be reviewed by IFSSA staff
LOC 44	Number of claims that failed edits or audits and must be reviewed by CSHCS staff
LOC 66	Number of claims denied
LOC 98	Number of claims approved to pay
TOTAL	Total number of claims received sorted by claim type and region code

Report:CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
DENTAL															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report:CTL-0140-D IndianaAIM Run Date : MM/DD/CCYY
Process: DAILY INCOMING CLAIM DISPOSITION SUMMARY Run Time: HH:MM:SS
Location: Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS Page: 999999
Actual Run Date: MM/DD/CCYY

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
PHARMACY															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report:CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
COMPOUND DRUG															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report :CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
HCFA 1500 XOVER															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report:CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
HCFA 1500															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
UB92 INST XOVER															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,99	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process
Location :

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
UB92 OUTP XOVER															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process :
Location :

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
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Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
HOME HEALTH															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
INPATIENT															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
LONG TERM CARE															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
OUTPATIENT															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
SHADOW															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page : 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
ALL CLAIM TYPES															
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
SUMMARY															
DENTAL	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
PHARMACY	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
COMPOUND DRUG	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
HCFA 1500 XOVER	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
HCFA 1500	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
UB92 INST XOVER	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
UB92 OUTP XOVER	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
HOME HEALTH	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
INPATIENT	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
LONG TERM CARE	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
OUTPATIENT	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
SHADOW	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

ORGINAL CLAIMS:

	DENTAL	PHARMACY	COMPOUND DRUG	HCFA 1500	HCFA 1500 XOVER	UB92 INST XOVER	UB92 OUTP XOVER	HOME HEALTH	INPATIENT	LONG TERM CARE	OUTPATIENT	SHADOW	TOTAL
TOTAL	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999

ADJUSTMENT CLAIMS:

	DENTAL	PHARMACY	COMPOUND DRUG	HCFA 1500	HCFA 1500 XOVER	UB92 INST XOVER	UB92 OUTP XOVER	HOME HEALTH	INPATIENT	LONG TERM CARE	OUTPATIENT	SHADOW	TOTAL
TOTAL	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999

DISPOSITION SUMMARY:

	DENTAL	PHARMACY	COMPOUND DRUG	HCFA 1500	HCFA 1500 XOVER	UB92 INST XOVER	UB92 OUTP XOVER	HOME HEALTH	INPATIENT	LONG TERM CARE	OUTPATIENT	SHADOW	TOTAL
SUSP	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999
DENY	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999
PAID	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999

END OF REPORT

CTL-0140-W All Extracted Crossover Claims, Part A

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0140-W		All Extracted Crossover Claims, Part A

Description of Information

The extracted claims report provides a detailed list of all Medicare Part A crossover claims received on the weekly claims file tape.

Purpose

List all Medicare Part A crossover claims coming to Medicaid via the magnetic tape process. This report pulls claim facsimiles for CPAS and SPR.

Sort Sequence

- *Primary* - Medicaid ICN
- *Secondary* - Medicaid RID

Distribution

To	Media	Copies	Frequency
FSSA	Paper	1	Weekly
EDS	Paper	1	Weekly

Detailed Field Definitions

HIB Number	Identifies the Medicare number of the member receiving service
Medicaid ICN	The internal control number assigned to the claim by Indiana*AIM*
Medicaid RID	The unique patient control number that identifies the recipient of the service.
Recipient Name	The member's full last name, first and middle initial
Service Dates	Indicates the first and last dates of service for the claim
Total Claim Chg	Indicates the first and last dates of service for the claim

```
REPORT: CTL-0140-W                                                                                 INDIANAAIM                                           DATE:  MM/DD/CCYY
PROCESS:                                                                                 ALL EXTRACTED CROSSOVER CLAIMS                                   TIME:  HH:MM:SS
LOCATION:                                                                                            PART-A                                                  PAGE:  9,999

HIB                                               MEDICAID            MEDICAID           RECIPIENT       SERVICE           SERVICE                  TOTAL
NUMBER                                            ICN                 RID                NAME            DATES             DATES                    CLAIM CHG
                                                                                                         FROM              THRU

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-

XXXXXXXXXXXXX                                   999999999999          999999999999      XXXXXXXXXXXXXXX    MMDDYY           MMDDYY                    999,999.99-
```

CTL-0141-D Daily Claim Disposition Summary

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0141-D		Daily Claim Disposition Summary

Description of Information

The report shows the number of claims processed by EDS daily and the disposition of the claims processed. Claim disposition is reflected by the claim location assigned to the claim. This report includes new day claims as well as corrected suspended claims.

Purpose

EDS uses the *Daily Claim Summary* to control and track the claims processed. It allows EDS to ensure that each claim processed is accounted for.

Sort Sequence

- *Primary* - Claim type
- *Secondary* - Region code

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Daily

Detailed Field Definitions

Claim Type

The type of claim form processed by EDS. Valid values:

Dental
Pharmacy
CMS-1500
Compound drug
CMS-1500 Xover
CMS-1500
UB-92 Inst Xover
UB-92 Outp Xover
Home Health
Inpatient
Long term care
Outpatient
Shadow

10

Number of paper claims processed by EDS without attachments

11	Number of paper claims processed by EDS with attachments
20	Number of ECS claims processed by EDS with no attachment indicators
21	Number of ECS claims processed by EDS with attachment indicators
22	Number of shadow claims processed by EDS
23	Number of Crossover claims submitted by providers using the Provider Electronic Solutions software and processed by EDS
25	Number of POS claims processed by EDS with no attachment indicators
40	Number of converted MMIS claims processed by EDS
41	Number of converted 590 MMIS claims processed by EDS
45	Number of converted MMIS adjustment claims processed by EDS
46	Number of converted 590 MMIS adjustment claims processed by EDS
50	Number of non-check related adjustments claims processed by EDS
51	Number of check related adjustment claims processed by EDS
54	Number of check voided mass adjustments processed by EDS
55	Number of nursing home adjustment claims processed by EDS
56	Number of financial adjustment claims processed by EDS
57	Number of mass adjustments reprocessed by EDS SEs
70	Number of HMO capitation claims processed by EDS
80	Number of claims reprocessed by EDS SEs
90	Number of special handling claims processed by EDS
Total	Total number of claims processed by claim type
Loc 00	Number of claims that failed validation edits
Loc 01	Number of claims that failed provider-related edits
Loc 02	Number of claims that failed recipient-related edits
Loc 03	Number of claims that failed PA-related edits
Loc 04	Number of claims that failed reference file-related edits
Loc 20	Number of claims that failed history-related duplication audits
Loc 21	Number of claims that failed medical policy-related audits
Loc 22	Number of claims that failed medical policy-related audits that require review by medical policy staff

Loc 23	Number of claims that failed for manual pricing
Loc 30	Number of claims that failed utilization review edits
Loc 40	Number of claims that generated CCFs back to providers for correction
Loc 43	Number of claims that failed edits or audits that must be reviewed by IFSSA staff
Loc 44	Number of claims that failed edits or audits that must be reviewed by CSHCS staff
Loc 66	Number of claims denied
Loc 98	Number of claims approved to pay
Total	Total number of claims processed sorted by claim type and region code

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
DENTAL																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
PHARMACY																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
COMPOUND DRUG																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
HCFA 1500 XOVER																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
HCFA 1500																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report:CTL-0141-D
Process:
Location Period:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
UB92 INST XOVER																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
UB92 OUTP XOVER																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
HOME HEALTH																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
INPATIENT																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
LONG TERM CARE																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

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Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
OUTPATIENT																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY H:MM:SS
Actual Run Date: MM/DD/CCYY

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Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
SHADOW																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0141-D
Process:
Location:

Indiana*AIM*
DAILY CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

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Run Time: HH:MM:SS
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CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22	LOC 23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
ALL CLAIM TYPES																
10 Paper	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
11 Paper w/Attachments	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
20 ECS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
22 Shadow Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
23 ECS Crossover Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
25 POS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
40 Converted MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
41 Converted 590 MMIS Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
45 Converted MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
46 Converted 590 MMIS Adj. Claims	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
50 Adjustments Non-Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
51 Adjustments Check Related	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
54 Mass Adjustments Check Void	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
55 Mass Adjustments Nursing Home	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
56 Mass Adjustments Financial	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
57 Mass Adjustments By EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
70 HMO Capitation/HMO	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
80 Claims Reprocessed by EDS SE's	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
90 Special Projects	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
TOTALS	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

Report: CTL-0140-D
Process:
Location:

Indiana*AIM*
DAILY INCOMING CLAIM DISPOSITION SUMMARY
Period: MM/DD/CCYY HH:MM:SS - MM/DD/CCYY HH:MM:SS
Actual Run Date: MM/DD/CCYY

Run Date : MM/DD/CCYY
Run Time: HH:MM:SS
Page: 999999

CLAIM TYPE	LOC 00	LOC 01	LOC 02	LOC 03	LOC 04	LOC 20	LOC 21/ 22/23	LOC 30	LOC 31	LOC 40	LOC 41	LOC 42/ 43/44	LOC 66	LOC 98	TOTAL
SUMMARY															
DENTAL	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
PHARMACY	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
COMPOUND DRUG	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
HCFA 1500 XOVER	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
HCFA 1500	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
UB92 INST XOVER	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
UB92 OUTP XOVER	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
HOME HEALTH	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
INPATIENT	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
LONG TERM CARE	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
OUTPATIENT	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999
SHADOW	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	9,999	99,999

	DENTAL	PHARMACY	COMPOUND DRUG	HCFA 1500	HCFA 1500 XOVER	UB92 INST XOVER	UB92 OUTP XOVER	HOME HEALTH	INPATIENT	LONG TERM CARE	OUTPATIENT	SHADOW	TOTAL
SUSP	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999
DENY	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999
PAID	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999	999,999,999

END OF REPORT

CTL-0141-W All Extracted Crossover Claims, Part B

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0141-W		All Extracted Crossover Claims, Part B

Description of Information

The extracted claims report provides a detailed list of all Medicare Part B crossover claims. This does not include DME claims.

Purpose

This report lists all Medicare Part B crossover claims coming to Medicaid via magnetic tape. It is used to pull claim facsimiles for CPAS and SPR.

Sort Sequence

- *Primary* - Medicaid ICN
- *Secondary* - Medicaid RID

Distribution

To	Media	Copies	Frequency
IFSSA	Paper	1	Weekly
EDS	Paper	1	Weekly

Detailed Field Definitions

HIB Number	Identifies the Medicare number of the member receiving service
Medicaid ICN	Internal control number assigned to the claim by IHCP
Medicaid RID	Patient control number that identifies the recipient of the service
Recipient Name	Member's full last name, first and middle initial
Service Dates	Indicates the first and last dates of service for the claim
Total Claim Chg	Total amount of all charges submitted on the claim

```
REPORT:  CTL-0141-W                                                       INDIANAAIM                           DATE:  MM/DD/CCYY
PROCESS:                                                        ALL EXTRACTED CROSSOVER CLAIMS                   TIME:  HH:MM:SS
LOCATION:                                                                   PART-B                                  PAGE:  9,999

HIB                     MEDICAID        MEDICAID       RECIPIENT        SERVICE         SERVICE         TOTAL
NUMBER                  ICN             RID            NAME             DATES           DATES           CLAIM CHG
                                                                        FROM            THRU
XXXXXXXXXXXX            999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
XXXXXXXXXXXXX           999999999999    999999999999   XXXXXXXXXXXXXXX  MMDDYY          MMDDYY          999,999.99
```

CTL-0142-W All Extracted Crossover Claims, DMERC

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0142-W		All Extracted Crossover Claims, DMERC

Description of Information

The Extracted Claims report provides a detailed list of all Medicare DMERC crossover claims. Regular Part B claims are not included in this report.

Purpose

This report lists all Medicare DMERC crossover claims coming to Medicaid via magnetic tape. It is used to pull claim facsimiles, if required, for CPAS and SPR.

Sort Sequence

- *Primary* - Medicaid ICN
- *Secondary* - Medicaid RID

Distribution

To	Media	Copies	Frequency
IFSSA	Paper	1	Weekly
EDS	Paper	1	Weekly

Detailed Field Definitions

HIB Number	Identifies the Medicare number of the member receiving service
Medicaid ICN	Identifies the Medicare number of the member receiving service
Medicaid RID	Patient control number that identifies the recipient
Recipient Name	Member's full last name, first and middle initials
Service Dates	First and last dates of service for the claim
Total Claim Chg	Total amount of all charges submitted on the claim

```
REPORT:  CTL-0142-W                                    INDIANAAIMDATE:  MM/DD/CCYY
PROCESS:                                     ALL EXTRACTED CROSSOVER CLAIMS                   TIME:  HH:MM:SS
LOCATION:                                                 DMERC PAGE:  9,999

HIB                 MEDICAID       MEDICAID       RECIPIENT         SERVICE       SERVICE        TOTAL
NUMBER              ICN            RID            NAME              DATES         DATES          CLAIM CHG
                                                                    FROM          THRU
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
XXXXXXXXXXXXX       999999999999   999999999999   XXXXXXXXXXXXXXX   MMDDYY        MMDDYY         999,999.99
```

CTL-0145-W Crossover File Summary

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0145-W		Crossover File Summary

Description of Information

The Program Process summary contains totals of the input and output files for Part A COB crossover claims tapes received from Medicare.

Purpose

This report is a summary of Part A Medicare-related claims submitted for processing by means of direct tape. It is used to analyze rejected claims and the reason for rejection. A tape received with a high number of rejections requires further research be performed on its content before processing can continue.

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Weekly

Detailed Field Definitions

Records Read	Number of Part A claim records read into the claims processing module for crossovers
Claims Built	Number of Part A claim records built on reading this data file. Multiple record types are read in to create one claim record.
Claims Rejected	Claims rejected and not tracked in Indiana*AIM*.
Provider Not Found	Claim rejected because the provider was not found on the cross-reference for Medicare provider and a IHCP provider
Missing Record	Claim did not have all the record types needed to build a
Types	Valid record types are 01 to 99. A minimum of 10-record (provider), 20-record (recipient), and 30-record (member ID) are needed to build a claim.
No Payment Due	Coinsurance and deductible amounts equal to zero
From Medicaid	Indicates no payment is due to the provider by IHCP

```
REPORT:  CTL-0145-W                                    INDIANAAIM                          DATE:  MM/DD/CCYY
PROCESS:                                C R O S S O V E R   F I L E   S U M M A R Y  -  P A R T - A    TIME:  HH.MM.SS
LOCATION:                                                                                   PAGE:  9,999

INPUT FILES:

                                    RECORDS                                        CLAIMS
          *--------------CLAIMS REJECTED-------------------*

                                    READ                                                  BUILT
                                           PROVIDER                                     MISSING
                                    NO PAYMENT DUE

                                                                        NOT FOUND
                  RECORD                                          FROM MEDICAID
MEDICARE PART-A (INDIANA)

                                    999,999,999                         999,999
    99,999,999                                  99,999,999                                  999,999

MEDICARE PART-A (WISCONSIN)

                                    999,999,999                         999,999
    99,999,999                                  99,999,999                                  999,999




                                                                  END OF REPORT
```

CTL-0146-W Crossover File Summary

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0146-W		Crossover File Summary

Description of Information

The program process summary contains totals of the input and output counts for Part B COB crossover claims tape received from Medicare. This does not include DME claims.

Purpose

This report is a summary of Part B Medicare-related claims submitted for processing by means of direct tape. It is used to analyze claims rejected and reasons for the rejection. A tape received with a high number of rejections requires further research on its content before processing can continue.

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Weekly

Detailed Field Definitions

Records Read	Number of Part B records read into the claims processing module for crossovers
Claims Built	Number of Part B claim records built on reading this data file. Multiple record types are read in to create one claim record.
Claims Rejected	Claims rejected and not tracked in Indiana*AIM*
Provider Not Found	Claim rejected because the provider was not found on the cross-reference for a Medicare provider and an IHCP provider
Missing Record Types	Claim did not have all the record types needed to build a valid claim. In order to build a valid claims record, at least one C11 (header) and one C21 (detail) record is required.
No Payment Due From Medicaid	Coinsurance and deductible amounts equal zero indicating that no payment is due to the provider by IHCP

```
REPORT:  CTL-0146-W                                  INDIANAAIM                          DATE:  MM/DD/CCYY
PROCESS:                          C R O S S O V E R   F I L E   S U M M A R Y  -  P A R T - B    TIME:  HH.MM.SS
LOCATION:                                                                                PAGE:  9,999

INPUT FILES:
RECORDS                                  CLAIMS          *--------------------CLAIMS REJECTED--------------------*
                                         READ            BUILT          PROVIDER       MISSING          NO PAYMENT DUE
                                                                         NOT FOUND      RECORD           FROM MEDICAID
MEDICARE PART-B (INDIANA)
                                         999,999,999     999,999        99,999,999     99,999,999       999,999


                                                    END OF REPORT
```

CTL-0147-W Crossover File Summary

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0147-W		Crossover File Summary

Description of Information

The program process summary contains totals of the input and output files for DMERC COB crossover claims received from Medicare.

Purpose

This report is a summary of DMERC Medicare-related claims submitted for processing by means of direct tape. It is used to analyze claims rejected and reasons for rejection. A tape received with a high number of rejections requires further research on its content before processing can continue.

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Weekly

Detailed Field Definitions

Records Read	Number of DMERC detail records read into the claims processing system
Claims Built	Number of DMERC claim records built on reading this data file. Multiple record types are read in to create one claim record.
Claims Rejected	Claims rejected and not tracked in Indiana*AIM*
Provider Not Found	Claims rejected because provider was not found on the cross-reference for NSC Supplier number and the Medicaid number
Missing Record Types	Claim did not have all the record types needed to build a valid claim. In order to build a valid record at least one C11 (header) and one C21 (detail) record must be present.
No Payment Due	Coinsurance and deductible amounts equal zero, indicating that no payment is due to the provider

```
REPORT:  CTL-0147-W                                INDIANAAIM                              DATE:  MM/DD/CCYY
PROCESS:                      C R O S S O V E R   F I L E   S U M M A R Y  -D M E R C       TIME:  HH.MM.SS
LOCATION:                                                                                   PAGE:  9,999
INPUT FILES:

RECORDS                 CLAIMS          *---------------CLAIMS REJECTED----------------*
READ                    BUILT              PROVIDER       MISSING        NO PAYMENT DUE
                                           NOT FOUND      RECORD         FROM MEDICAID
MEDICARE DMERC (INDIANA)
999,999,999             999,999            99,999,999     99,999,999     999,999


                                        END OF REPORT
```

CTL-0150-D Edit / Audit Failure Variance

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0150-D		Edit / Audit Failure Variance

***This report is currently in SME review. 12/27/00*

CTL-0151-W Invalid Medicare Part A/C Providers

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0151-W	CLMJW440	Invalid Medicare Part A/C Providers

Description of Information

The CTL-151-W Invalid Medicare Part A/C Providers report lists all invalid providers from the UB92 Crossover Part A/C Tape - AdminaStar. The invalid providers are sorted by the number of occurrences of the tax ID and the Medicare ID. The report lists the Medicare ID, the provider's first and last name, tax ID, address, city, state, and ZIP code.

Purpose

This report lists all invalid Medicare providers and their information according to the number of occurrences of the tax ID.

Sort Sequence

Tax ID (number of occurrences)

Medicare ID

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

Medicare ID	Provider's Medicare identification number
First name	Provider's first name
Last name	Provider's last name
Tax ID	Provider's tax identification number which is sorted according to number of occurrences
Address	Provider's address
City	Provider's city
State	Provider's state
ZIP Code	Provider's ZIP code

Report: CTL-0151-W IndianaAIM PAGE : 1
Process: CLMJW440 Invalid Medicare Part A/C Providers
Location UB92 TAPE RUN DATE: MM/DD/CCYY

Medicare ID	First Name	Last Name	Tax ID	Address	City	State	ZIP Code
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX

CTL-0152-D Aged Claims Listing

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0152-D		Aged Claims Listing

Description of Information

The CTL-152-D *Aged Claims Listing* reports electronic (Region 20 and 23) aged clean claims for the IHCP not resolved within 15 days. The report is sorted by Julian date. The report displays the current system location of the claim and how long it has been in that location. The report is reviewed daily, and all claims listed on the report are given priority during claim resolution. Each claim is researched to determine the cause of the suspense age, and appropriate measures are taken to ensure timely adjudication of the suspended claim. Claims that have spent any time in locations 20 (Medical Review), 30 (SUR), or 40 (CCF) are not considered clean claims under SB175. Therefore, claims that have spent any time in these locations are not included on this report. The age of the ICN is the Julian date minus the report date. Adjustments are excluded from this report.

Purpose

EDS uses the *Aged Claim Listing* report to list all claims 15 days or older currently suspended in the system. This report automatically prints if claims are aging 15 days or older.

Sort Sequence

- *Primary* - Julian date of ICN
- *Secondary* - Location

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	2	Daily

Detailed Field Definitions

CT	One-byte field representing claim type. Valid values: D – Dental S – Shadow H – Home health L – Long term care M – Medical I – Inpatient O – Outpatient P – Pharmacy X – Crossover A, B, and C Q – Compound drug
ICN	Unique number assigned to a claim processed in the system for internal control purposes. The ICN is in RRCCYYJJJBBBSSS format. R – Region C – Century Y – Year J – Julian date B – Batch S – Sequence
RID	System-assigned unique number used to identify a member
Bill Prov	System-assigned unique number used to identify a provider
Elsp Days	Number of days the claim has been in Indiana*AIM* without being adjudicated. Claims that spend any time in locations 22, 30, or 40 are not considered clean claims and are not included in this report. For example, a claim is currently in location 00 and is 15 days old. However, since it spent 1 day in location 22, it is not clean and is not reported. The number of days is calculated by subtracting the ICN Julian date from the Report Date.
Loc Cd	Location code where the claim is currently held in suspense
Loc Dt	Date claim entered this location
Days Loc	Number of days the claim has been in this location (Current date minus Location date)
Aged Claims	Total number of claims not adjudicated and more than 15 days old

```
Report:  CTL-0130-D                                                       IndianaAIM                       Run Date:  CCYY/MM/DD
Process:                                                                                                   Page Number:   99,999
Location:                                                            AGED CLAIMS LISTING


                      CT          ICN               RID          BILL PROV    ELSP DAYS   LOC CD     LOC DT       DAYS LOC
                       X     9999999999999     999999999999     999999999       999         XX       MMDDYY         999
                       X     9999999999999     999999999999     999999999       999         XX       MMDDYY         999
                       X     9999999999999     999999999999     999999999       999         XX       MMDDYY         999
                       X     9999999999999     999999999999     999999999       999         XX       MMDDYY         999
                       X     9999999999999     999999999999     999999999       999         XX       MMDDYY         999
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                       X     9999999999999     999999999999     999999999       999         XX       MMDDYY         999


                                                             TOTAL AGED CLAIMS:  9999
                                                              AGED CLAIMS:  999999999
                                                                   End of Report
```

CTL-0154-W Invalid Medicare Part B Billing Providers

Functional Area	Report Number	Job Name	Report Title
Provider Enrollment/Claims	CTL-0154-W	CLMJW430	Invalid Medicare Part B Billing Providers

Description of Information

The CTL-154-W Invalid Medicare Part B Billing Providers report lists all invalid-billing providers from the CMS report. The invalid billing providers are sorted according to the number of occurrences of the tax ID and Medicare ID. The report lists the Medicare ID, provider's first and last name, tax ID, address, city, state, and ZIP code.

Purpose

The Invalid Medicare Part B Billing Providers report lists all invalid Medicare providers, along with their information according to the number of occurrences of the tax ID.

Sort Sequence

- *Primary* - Tax ID (Number of occurrences)
- *Secondary* - Medicare ID

Distribution

To	Media Type	Copies	Frequency
EDS	Paper/CRLD	1	Weekly

Detailed Field Definitions

Medicare	Billing provider's Medicare ID
First Name	Billing provider's first name
Last Name	Billing provider's last name
Tax ID	Billing provider's tax ID, sorted by number of occurrences
Address	Billing provider's address
City	Billing provider's city
State	Billing provider's state
ZIP Code	Billing provider's ZIP code

REPORT: CTL-0154-W Indiana*AIM* PAGE: 1
LOCATION:HCFARPT Invalid Medicare Part B Billing Providers
JOB SCRIPT:CLMPW430 RUN DATE: 11/16/2000

Medicare ID	First Name	Last Name	Tax ID	Address	City	State	ZIP Code
XXXXXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX

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CTL-0155-W Invalid Medicare Part B Rendering Providers

Functional Area	Report Number	Job Name	Report Title
Provider Enrollment/Claims	CTL-0155-W	CLMJW430	Invalid Medicare Part B Rendering Providers

Description of Information

The Invalid Medicare Part B Rendering Providers report lists all invalid-rendering providers from the CMS report. Invalid rendering providers are sorted according to the number of occurrences of the tax ID and the Medicare ID. The report lists the Medicare ID, provider's first and last name, tax ID, address, city, state, and ZIP code.

Purpose

The Invalid Medicare Part B Rendering Providers report lists all invalid Medicare rendering providers, along with their information.

Sort Sequence

N/A

Distribution

To	Media Type	Copies	Frequency
EDS	Paper/CRLD	1	Weekly

Detailed Field Definitions

Medicare ID	Rendering provider's Medicare ID
First Name	Rendering provider's first name
Last Name	Rendering provider's last name
Tax ID	Rendering provider's tax ID, sorted according to number of occurrences
Address	Rendering provider's address
City	Rendering provider's city
State	Rendering provider's state
ZIP Code	Rendering provider's ZIP code

REPORT: CTL-0154-W IndianaAIM PAGE: 1
LOCATION: HCFARPT Invalid Medicare Part B Rendering Providers
JOB SCRIPT: CLMPW430 Date Tape Created: 11/12/2000 RUN DATE: 11/16/2000

Medicare ID	First Name	Last Name	Tax ID	Address	City	State	ZIP Code
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX

CTL-0156-W Crossover File Summary – Part-A/C

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0156-W	CLMJW450	Crossover File Summary – Part A/C

Description of Information

The CTL-156-W Crossover File Summary – Part-A/C report from the UB92 Crossover Part A/C tape –Wisconsin - lists the number of records read, the number of claims built, the number of records of which the provider was not found, the number of missing records, and the number of claims in which there is no payment due from Medicaid.

The no payment due from Medicaid column lists the number of claims in which there is a zero amount in the deductible and co-insurance fields.

The number of claims built is the number of claims built minus the number of claims where there is no payment due from Medicaid.

Purpose

The Crossover File Summary – Part-A/C report indicates the total number of records read from the UB92 tape and the total number of claims built from those records.

Sort Sequence

N/a

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

RECORDS READ	Total number of records read from the UB92 Crossover tape
CLAIMS BUILT	Total number of claims built minus the number of claims where there is no payment due from Medicaid
PROVIDER NOT FOUND	Number of claims in which the Medicaid ID is not found
MISSING RECORD	Number of records missing
NO PAYMENT DUE FROM MEDICAID	Claims in which there is no payment due from Medicaid. The claims in which there are zero amounts in the deductible and co-insurance fields.

```
Report : CTL-0156-W                                    IndianaAIM                    Run Date: CCYY/MM/DD
Process: CLMJW450                              CROSSOVER FILE SUMMARY PART-A/C       Run Time: HH/MM/SS
Location UB92 TAPE                                    STATE = INDIANA               Page Number: 99,999


                                                      *-------------------CLAIMS REJECTED-------------------*
INPUT FILES:          RECORDS READ     CLAIMS BUILT     PROVIDER NOT FOUND    MISSING RECORD   NO PAYMENT DUE FROM MEDICAID
MEDICARE PART-A/C     999,999          999,999          999,999               999,999          999,999

(INDIANA)
```

CTL-0157-W Crossover File Summary – Part-A/C

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0157-W	CLMJW460	Crossover File Summary – Part-A/C

Description of Information

The CTL-157-W Crossover File Summary – Part-A/C report from the UB92 Crossover Part A/C tape –Omaha - lists the number of records read, the number of claims built, the number of records of which the provider was not found, the number of missing records, and the number of claims in which there is no payment due from Medicaid.

The no payment due from Medicaid column lists the number of claims in which there is a zero amount in the deductible and co-insurance fields.

The number of claims built is the number of claims built minus the number of claims where there is no payment due from Medicaid.

Purpose

The Crossover File Summary – Part-A/C report indicates the total number of records read from the UB92 tape and the total number of claims built from those records.

Sort Sequence

N/a

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

RECORDS READ	Total number of records read from the UB-92 Crossover tape
CLAIMS BUILT	Total number of claims built minus the number of claims where no payment is due from Medicaid
PROVIDER NOT FOUND	Number of claims in which the Medicaid ID is not found
MISSING RECORDS	Number of records missing
NO PAYMENT DUE FROM MEDICAID	Claims where no payment is due from Medicaid. The claims in which there are zero amounts in the deductible, co-insurance, and psychiatric adjustment fields.

```
Report  : CTL-0157-W                                        IndianaAIM                    Run Date:  CCYY/MM/DD
Process : CLMJW460                                CROSSOVER FILE SUMMARY PART-A/C         Run Time:    HH/MM/SS
Location: UB92 TAPE                                      STATE = INDIANA                  Page Number:   99,999

                                                        *-------------------CLAIMS REJECTED-------------------*
INPUT FILES:          RECORDS READ     CLAIMS BUILT     PROVIDER NOT FOUND    MISSING RECORD   NO PAYMENT DUE FROM MEDICAID
MEDICARE PART-A/C     999,999          999,999          999,999               999,999          999,999


(INDIANA)
```

CTL-0158-W Invalid Medicare Part A/C Providers

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0158-W	CLMJW450	Invalid Medicare Part A/C Providers

Description of Information

The CTL-158-W Invalid Medicare Part A/C Providers report lists all invalid providers from the UB92 Crossover Part A/C Tape - Wisconsin. The invalid providers are sorted according to the number of occurrences of the tax ID and the Medicare ID. The report lists the Medicare ID, the provider's first and last name, tax ID, address, city, state, and ZIP code.

Purpose

The Invalid Medicare Part A/C Billing Providers report lists all invalid Medicare providers along with their information according to the number of occurrences of the tax id.

Sort Sequence

Tax ID (Number of occurrences)

Medicare ID

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

MEDICARE ID	Provider's Medicare identification number
FIRST NAME	Provider's first name
LAST NAME	Provider's last name
TAX ID	Provider's tax identification number, which is sorted according to number of occurrences.
ADDRESS	Provider's address
CITY	Provider's city
STATE	Provider's state
ZIP CODE	Provider's ZIP code

```
Report     : CTL-0158-W                              Indiana AIM                                                 PAGE : 1
Process    : CLMJW450                      Invalid Medicare Part A/C Providers
Location   : UB92 TAPE
                                                                                                                     RUN
DATE: MM/DD/CCYY

Medicare ID      First Name       Last Name         Tax ID      Address                          City                State
ZIP Code
-----------------------------------------------------------------------------------------------------------------------------
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XXXXX-XXXX
```

CTL-0159-W Invalid Medicare Part A/C Providers

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0159-W	CLMJW460	Invalid Medicare Part A/C Providers

Description of Information

The CTL-151-W Invalid Medicare Part A/C Providers report lists all invalid providers from the UB92 Crossover Part A/C Tape - Omaha. The invalid providers are sorted according to the number of occurrences of the tax ID and the Medicare ID. The report lists the Medicare ID, the provider's first and last name, tax ID, address, city, state, and ZIP code.

Purpose

This report lists all invalid Medicare providers along with their information according to the number of occurrences of the tax id.

Sort Sequence

Tax ID (Number of occurrences)

Medicare ID

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

MEDICARE ID	Provider's Medicare identification number
FIRST NAME	Provider's first name
LAST NAME	Provider's last name
TAX ID	Provider's tax identification number which is sorted according to number of occurrences
ADDRESS	Provider's address
CITY	Provider's city
STATE	Provider's state
ZIP CODE	Provider's ZIP code

```
Report: CTL-0159-W                       IndianaAIM                              PAGE : 1
Process: CLMJW460              Invalid Medicare Part A/C Providers
Location: UB92 TAPE                                                   RUN DATE: MM/DD/CCYY
```

Medicare ID	First Name	Last Name	Tax ID	Address	City	State	ZIP Code
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
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CTL-0166-W Crossover File Summary – Part-A/C

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0166-W	CLMJW495	Crossover File Summary – Part-A/C

Description of Information

The CTL-156-W Crossover File Summary – Part-A/C report from the UB-92 Crossover Part A/C tape –Riverbend - lists the number of records read, the number of claims built, the number of records of which the provider was not found, the number of missing records, and the number of claims in which there is no payment due from Medicaid.

The no payment due from Medicaid column lists the number of claims in which there is a zero amount in the deductible and co-insurance fields.

The number of claims built is the number of claims built minus the number of claims where there is no payment due from Medicaid.

Purpose

This report indicates the total number of records read from the UB-92 tape and the total number of claims built from those records.

Sort Sequence

N/a

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

RECORDS READ	Total number of records read from the UB92 Crossover tape
CLAIMS BUILT	Total number of claims built minus the number of claims where there is no payment due from Medicaid
PROVIDER NOT FOUND	Number of claims in which the Medicaid ID is not found
MISSING RECORDS	Number of records missing
NO PAYMENT DUE FROM MEDICAID	Claims in which no payment is due from Medicaid. The claims in which there are zero amounts in the deductible and co-insurance fields.

```
Report  :  CTL-0166-W                              IndianaAIM                                Run Date:
06/21/01
Process :  CLMJW495                    CROSSOVER FILE SUMMARY - PART-A/C                 Run Time:
16:20:41.3
Location: UB92TAP6                           STATE =  RIVERBEND                          Page    :


                                  *------------------CLAIMS REJECTED------------------*

                                  RECORDS        CLAIMS       PROVIDER          MISSING        NO PAYMENT DUE
INPUT FILES:                      READ           BUILT        NOT FOUND         RECORD         FROM MEDICAID

MEDICARE PART A/C RIVERBEND         00000           00             00                0                0

                                           END OF REPORT
```

CTL-0167-W Invalid Medicare Part A/C Providers

Functional Area	Report Number	Job Name	Report Title
Claims	CTL-0167-W	CLMJW495	Invalid Medicare Part A/C Providers

Description of Information

The CTL-158-W Invalid Medicare Part A/C Providers report lists all invalid providers from the UB92 Crossover Part A/C Tape - Riverbend. The invalid providers are sorted according to the number of occurrences of the tax ID and the Medicare ID. The report lists the Medicare ID, the provider's first and last name, tax ID, address, city, state, and ZIP code.

Purpose

This report lists all invalid Medicare providers and their information according to the number of occurrences of the tax ID.

Sort Sequence

Tax ID (Number of occurrences)

Medicare ID

Distribution

To	Media	Copies	Frequency
EDS	CO-MAND	1	Weekly

Detailed Field Definitions

MEDICARE ID	Provider's Medicare identification number
FIRST NAME	Provider's first name
LAST NAME	Provider's last name
TAX ID	Provider's tax identification number which is sorted according to number of occurrences
ADDRESS	Provider's address
CITY	Provider's city
STATE	Provider's state
ZIP CODE	Provider's ZIP code

```
Report Name :CTL-0167                    IndianaAIM                              Run Date: 6/21/2001
PROCESS : CLMJW495           Invalid Medicare Part A/C Providers                   Run Time: 16:21
Location : CLMPW442               STATE NAME : RIVERBEND                                 Page: 1
```

Medicare ID	First Name	Last Name	Tax ID	Address	City	State	ZIP Code
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
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XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
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XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX
XXXXXXXXXXXXXXX	XXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XX	XXXXX-XXXX

Section 10: ECC Reports

ECC-0001-D ECC Biller Summary Report

Functional Area	Report Number	Job Name	Report Title
Electronic Claim Capture	ECC-0001-D		ECC Biller Summary Report

Description of Information

The ECC Biller Summary (ECC-0001-D) report provides magnetic tape, diskette, and cartridge claim submitters with information regarding submitted claims that contained errors so severe that they were not able to continue through the claim processing cycle. These reports also identify the reason(s) the claims rejected prior to entry in Indiana*AIM*.

Purpose of Report

The purpose of the ECC Biller Summary Report is to provide magnetic tape, diskette, and cartridge senders the opportunity to correct claim errors almost immediately after the submission of the claim file and resubmit the claim(s).

Sort Sequence

- *Primary -* Hour

Distribution

To	Media	Copies	Frequency
Providers	Paper	1	Daily
Software Vendors	Paper	1	Daily

Detailed Field Definitions

Submission Time	HH:MM and MM/DD/YY the file was submitted to EDS
Submission Type	Method of submission and type of claim submitted ASYN Asynchronous-Xmodem UUCP Asynchronous-UUCP RREI Bisynchronous NECS Nat'l Electronic Claim Submission or Provider Electronic Solutions (EDS' products) T Magnetic Tape D Diskette CART Cartridge Tape and diskette billers have many size, densities and other options with which to submit. They are not all listed in this document; however, tape and diskette submissions can be identified with a leading T or D respectively.
Provider Number	Indiana provider number
Provider Level Errors	Errors at the provider level that cause an entire batch to reject. Refer to *Appendix A* for a complete listing of all rejection codes. Up to three occurrences are reported. On claims with three or more errors, the third error code is 999. 000 represents no error code.

Received Claims	Number of claims accepted for further processing
Rejected Claims	Number of claims rejected because of errors so severe that the claim could not continue processing
Billed Amount	Total dollar amount of claim accepted for further processing
Recipient	First five characters of the recipient's last name and the first character of the recipient's first name
RID	12-digit recipient identification number
DOS	From date of service on the claim
Control No	Provider's internal number assigned to a patient. For pharmacies, this is the prescription number.
Bill Amt.	Sum of all details on the claim
Error Codes	Detail errors that caused the claim to reject. Up to three occurrences are reported. On claims with three or more errors, the third error code is 999. 000 represents no error code. indicates that this information is only displayed for rejected claims
Errors Not Specific To A Claim Sender Level/Trailer Level	Errors that would cause an entire file to be rejected. Up to three occurrences will be reported. 000 represents no error code.
Total Records	Total number of records submitted in the batch
Total Claims Received	Total number of claims received. Includes both accepted and rejected claims
Total Amount Billed	Total dollar amount of claim accepted for further processing. Includes all providers in submission
Total Claims Accepted	Total number of claims in the batch that are accepted for further processing
Total Claims Rejected	Total number of claims in the batch that are rejected

```
Report: ECC-0001-D   Indiana Health Coverage Programs       Run Date: MM/DD/CCYY
Process:ECSTAPE        Electronic Claims Submission          Run Time: HH:MM XM
                           Biller Summary Report


XXXXXXXXXXXX (XXXX)                          Submission Time: HH:MM XM MM/DD/CCYY

Provider Number: XXXXXXXXX                   Provider Level Errors: 999  999  999

Received:
         Claims:   99999999                  Billed Amount: $   999999999.99
Rejected:
         Claims:   99999999

Recipient    RID           DOS              Control No.   Bill Amt.  Error Codes
-----------  ------------  ---------------  ------------  ---------  -----------
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999
XXXXX, X     999999999999  999999999999     999999999999  999999999  999 999 999



ERRORS NOT SPECIFIC TO A SINGLE CLAIM:
      Sender Level:   999  999  999
      Trailer Level:  999  999  999


Total records:              99999999
Total Claims Received:      99999999
Total Amount Billed:   $ 99999999999
Total Claims Accepted:      99999999
Total Claims Rejected:      99999999
```

ECSCLAIM ECS Daily Claim Count

Functional Area	Report Number	Job Name	Report Title
Electronic Claim Capture	ECSCLAIM		ECS Daily Claim Count

***This report is currently in SME review. 12/27/00*

Description of Information

The ECS Daily Claim Count Report provides counts for the number of claims transmitted electronically (batch only – not POS) by claim type. The report lists the number of claims received during each 30 minute time period from 9 am to 6 pm. Any claim received after the last reading for the day is included in the first reading of the following day.

Purpose of Report

The report reports the number of electronic claims received daily, by time of day transmitted.

Sort Sequence

- *Primary -* Half hour

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Daily

```
                                        ECS DAILY CLAIM COUNTS

MM/DD/YY                                                                                          Page 1

 Run Time    Dental   Home Health   Inpatient   Nursing   Medical   Outpatient   Pharmacy    Q     Total
========================================================================================================
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
 hh:mm        999         999          999        999       9999        999          9        9     99999
             9999        9999         9999       9999      99999       9999       9999        9     99999

                                        ** End of Report **
```

Section 11: ELG Reports

ELG-0001-D Total ID Card Counts By County

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0001-D		Total ID Card Counts by County

Description of Information

This report lists each of the 92 counties alphabetically with the total number of ID cards that the county issued each day. This number includes all replacement cards or new cards with the following codes from the ID Card Window:

- Y New recipient card
- L Lost card
- S Stolen card
- D Damaged card
- R Replacement card or Re-enrolled recipient
- C Changed information to the face of the ID card (Name, RID, Date of Birth)

A "Total" column at the end of report displays the number of cards printed for the State of Indiana for that week. This number is calculated by adding all 92 county card totals together for a grand total.

Purpose

The purpose of the Total ID Card Counts by County report is to allow EDS and IFSSA to view the daily counts for the ID card generation.

Sort Sequence

- Primary - County name, alphabetically

The total number of Medicaid and CSHCS cards printed for each county is listed to the right of the county name. There is also a total at the bottom of the report with the entire number of cards printed for all 92 counties for that week.

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Daily
IFSSA	CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

County	Two character alphabetic describing the recipient's county in Indiana
Number Of Cards Issued	Lists the total number of plastic ID cards issued to recipients in that county for that day
Total	The total number of plastic ID cards issued for the 92 counties in Indiana

Report: ELG-0001-W
Process:
Location: HMKI8000

Indiana*AIM*
TOTAL ID CARD COUNTS BY COUNTY

Run Date: MM/DD/CCYY
Run Time: HH:MM
Page Number: 99,999

COUNTY	NUMBER OF CARDS ISSUED
ADAMS	106
ALLEN	345
BARTHOLOMEW	122
BENTON	456
TOTAL:	**1029**

ELG-0001-M Monthly Reconciliation Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0001-M	ELGJM300	Eligibility Monthly Reconciliation Report

Description of Information

- Recipient Medicaid ID
- Aid Category
- Eligibility Effective Date
- Eligibility End Date
- Status Code

Purpose

A report must be created to print changed eligibility rows that were previously open before the reconciliation processing but were closed during the reconciliation processing.

Sort Sequence

Aid Category

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
OMPP	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Recipient Medicaid ID	Recipient identification number
Aid Category	Category of medical assistance for which the recipient is qualified
Eligibility Effective Date	Start date of the eligibility segment
Eligibility End Date	End date of the eligibility segment

Status Code	Indicates if the record has been changed to a **history** status

REPORT: ELG-0001-M IndianaAIM RUN DATE: MM/DD/CCYY
PROCESS: ELGPM001 MONTHLY RECONCILIATION REPORT RUN TIME: HH:MI

This report shows all aid eligibility segments that were open until 22991231 prior to the MON CCYY reconciliation and were closed as a result of the MON CCYY reconciliation. The eligibility segments are now closed on a date prior to MM/DD/CCYY, the date of the MON CCYY reconciliation. The report is sorted on Aid Category.

RECIPIENT MEDICAID ID	AID CATEGORY	ELIGIBILITY EFFECTIVE DATE	ELIGIBILITY END DATE	STATUS CODE .
XXXXXXXXXXX	XX	MM/DD/CCYY	MM/DD/CCYY	X

END OF REPORT

ELG-0002-D ID Card Summary

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0002-D		ID Card Summary

Description of Information

This report lists the total number of ID cards generated according to the reason codes from the ID Card Window. The reasons are listed as follows with the total count for each day to the direct right of the reason:

- New recipient card
- Lost card
- Stolen card
- Damaged card
- Replacement card or Re-enrolled recipient
- Changed information to the face of the ID card (Name, RID, Date of Birth)

A "Total" line displays how many cards were actually generated for the week.

Purpose

The ID Card Summary Report allows EDS and IFSSA to view the types of cards by percentages sent to recipients.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

New Recipient Card	Total number of cards printed for new recipients
Lost	Total number of cards printed for the recipients who lost their cards

Stolen	Total number of cards printed for the recipients whose cards were stolen
Damaged	Total number of cards printed for recipients who had a damaged card that needed to be replaced
Replacement or Re-enrolled	The total number of replacement cards or cards generated for recipients who are re-enrolling
Changed ID information	The total number of cards issued for recipients who have changed their name, RID, or date of birth and must have an updated card with correct information
Total	This is the total number of cards generated daily for all 92 counties

Report: ELG-0002-D
Process:
Location: HMKI8000

ID CARD SUMMARY

Run Date: MM/DD/CCYY
Run Time: HH:MM
Page Number:

NEW RECIPIENT:	131
LOST:	220
STOLEN:	410
DAMAGED:	105
REPLACEMENT OR RE-ENROLL:	315
CHANGED ID INFORMATION:	109
TOTAL:	1290

ELG-0002-M Monthly Reconciliation Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0002-M	ELGJM300	Eligibility Monthly Reconciliation Report

Description of Information

- Recipient Medicaid ID
- Aid Category
- Eligibility Effective Date
- Eligibility End Date
- Status Code

Purpose

A report must be created to print changed eligibility rows that were previously closed (but had a close date in the future) before the reconciliation processing, and the end date was modified to an end date prior to the reconciliation processing date.

Sort Sequence

Aid Category

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
OMPP	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Recipient Medicaid ID	Recipient identification number
Aid Category	Category of medical assistance for which the recipient is qualified
Eligibility Effective Date	Start date of the eligibility segment
Eligibility End Date	End date of the eligibility segment

Status Code	Indicates if the record has been changed to a **history** status

REPORT: ELG-0002-M IndianaAIM RUN DATE: MM/DD/CCYY
PROCESS: ELGPM001 MONTHLY RECONCILIATION REPORT RUN TIME: HH:MI

This report shows all aid eligibility segments that were closed in the future, prior to the reconciliation, and were closed as a result of the MON CCYY reconciliation. The eligibility segments were closed on a date prior to MM/DD/CCYY end date of the MON CCYY reconciliation. The report is sorted on Aid Category.

RECIPIENT MEDICAID ID	AID CATEGORY	ELIGIBILITY EFFECTIVE DATE	ELIGIBILITY END DATE	STATUS CODE .
XXXXXXXXXXX	XX	MM/DD/CCYY	MM/DD/CCYY	X

END OF REPORT

ELG-0003-D ICES Eligibility Update Error

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0003-D		ICES Eligibility Update Error Report

Description of Information

This report lists the fields attempted as adds or updates that ICES transmitted to EDS but have failed edits in the Indiana*AIM* database. A brief message explaining each error and a brief description of what action was taken are indicated on the report. These transactions must be corrected in ICES so the appropriate action is transmitted to Indiana*AIM*.

Purpose

The purpose of the ICES Eligibility Update Error Report is to provide EDS and IFSSA with information regarding field edits for transactions not accepted from ICES.

Sort Sequence

- *Primary* - County number, ascending (1-92)

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Daily
IFSSA	CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Field In Error	The field where an error is indicated on the ICES tape.
Field Value	The value passed from ICES
Message	A brief description of why an add or an update did not take place
Action Taken	The action taken on the record
TXN	Three character code sent to Indiana*AIM* to describe the transaction. Valid values:

	ADD = add, *UPD* = update
RID	Recipient identification number
Name	Recipient's full name (first name last name MI)
SSN	Recipient's social security number
Birth Date	The recipient's date of birth in MM DD CCYY format
Case #	Ten numeric characters assigned by ICES to the recipient (when available)
Worker	Six character alphanumeric caseworker number assigned to this recipient

Report: ELG-0003-D
Process:
Location:

Indiana*AIM*

Run Date: MM/DD/CCYY
Page Number:

ICES ELIGIBILITY UPDATE ERROR REPORT

FIELD IN ERROR	FIELD VALUE	MESSAGE	ACTION TAKEN
TXN UPD RID 120000000699 NAME FADI BERMUDA SSN 308114939 BIRTH DATE 10-29-1992 CASE# 1929292929 WORKER W01233			
CDE ISSUE RSN s		ID CARD ISSUE REASON CODE IS INVALID	NO CARD
TXN UPD RID 120000000799 NAME FRANCOIS PAUL SSN 308113339 BIRTH DATE 10-29-1989 CASE# 1444292929 WORKER W01243			
CDE ISSUE RSN s		ID CARD ISSUE REASON CODE IS INVALID	NO CARD
TXN UPD RID 120000001399 NAME ISABEL GABRIEL SSN 313626444 BIRTH DATE 06-18-1961 CASE# 1000292929 WORKER W01233			
SPEND MET DT	19641210	NO SPENDDOWN PERIOD EXISTS FOR THIS SPEND MET DT	REJECT FLD
SPEND MET DT	19931101	NO SPENDDOWN PERIOD EXISTS FOR THIS SPEND MET DT	REJEDT FLD
CDE PGM		PROGRAM CODE IS MISSING OR INVALID	
TXN UPD RID 120000000229 NAME DANA PETER SSN 308994939 BIRTH DATE 11-20-1992 CASE# 1929292929 WORKER W01233			
NAME/DOB		CANNOT ADD DUPLICATE RECIPIENT	REJECT FLD

END OF REPORT
NO DATA THIS REPORT

ELG-0003-M Monthly Reconciliation Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0003-M	ELGJM300	Eligibility Monthly Reconciliation Report

Description of Information

- Recipient Medicaid ID
- Aid Category
- Eligibility Effective Date
- Eligibility End Date
- Status Code

Purpose

A report must be created to print changed eligibility rows that were previously closed before the reconciliation processing and were reopened after reconciliation processing.

Sort Sequence

Aid Category

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
OMPP	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Recipient Medicaid ID	Recipient identification number
Aid Category	Category of medical assistance for which the recipient is qualified
Eligibility Effective Date	Start date of the eligibility segment
Eligibility End Date	End date of the eligibility segment

Status Code	Indicates if the record has been changed to a **history** status

REPORT: ELG-0003-M IndianaAIM RUN DATE: MM/DD/CCYY
PROCESS: ELGPM001 MONTHLY RECONCILIATION REPORT RUN TIME: HH:MI

This report shows all aid eligibility segments that were closed prior to the MON CCYY reconciliation, but are now open until 22991231 as a result of the MON CCYY reconciliation. The report is sorted on Aid Category.

RECIPIENT MEDICAID ID	AID CATEGORY	ELIGIBILITY EFFECTIVE DATE	ELIGIBILITY END DATE	STATUS CODE .
XXXXXXXXXXX	XX	MM/DD/CCYY	MM/DD/CCYY	X

END OF REPORT

ELG-0004-M Monthly Reconciliation Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0004-M	ELGJM300	Eligibility Monthly Reconciliation Report

Description of Information

- Recipient Medicaid ID
- Aid Category
- Eligibility Effective Date
- Eligibility End Date
- Status Code

Purpose

A report must be created to print changed eligibility rows that were previously closed before the reconciliation processing and are still closed after the reconciliation processing, but the end date was modified.

Sort Sequence

Aid Category

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
OMPP	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Recipient Medicaid ID	Recipient identification number
Aid Category	Category of medical assistance for which the recipient is qualified
Eligibility Effective Date	Start date of the eligibility segment
Eligibility End Date	End date of the eligibility segment

Status Code	Indicates if the record has been changed to a **history** status

REPORT: ELG-0004-M IndianaAIM RUN DATE: MM/DD/CCYY
PROCESS: ELGPM001 MONTHLY RECONCILIATION REPORT RUN TIME: HH:MI

This report shows all aid eligibility segments that were closed prior to the MON CCYY reconciliation and are still closed, but the end date was modified as a result of the MON CCYY reconciliation. The report is sorted on Aid Category.

RECIPIENT MEDICAID ID	AID CATEGORY	ELIGIBILITY EFFECTIVE DATE	ELIGIBILITY END DATE	STATUS CODE .
XXXXXXXXXXX	XX	MM/DD/CCYY	MM/DD/CCYY	X

END OF REPORT

ELG-0005-D 590 Recipient Eligibility Update Error Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0005-D		590 Recipient Eligibility Update Error Report

Description of Information

The 590 Recipient Eligibility Update Error Report (ELG-0005-W) lists the attempted 590 recipients eligibility adds or updates not accepted in the Indiana*AIM* database. Any errors detected during the Update 590 Recip Elig batch process are written to an error table. After the update batch process is completed, the error table is read, and the report is created from the transactions marked as errors. A brief message explaining each error and a brief description of what action was taken are indicated on the report. These transactions must be corrected so the appropriate action is taken.

Purpose

The purpose of the 590 Recipient Eligibility Update Error Report is to provide EDS with information regarding transactions that were not accepted.

Sort Sequence

- *Primary -* RID number.

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

RID	590 Recipient identification number
Name	590 Recipient's full name (last name, first name, MI)
SSN	590 Recipient Social Security Number
Birth Date	590 Recipient Date of Birth
Message	A brief description of why an add or an update did not take place
Action Taken	The action taken on the record

```
Report:  ELG-0005-D                                     IndianaAIM                                 RUN DATE:  MM/DD/CCYY
Process:                                                                                                TIME: HH:MM:SS
Location:                                 590 RECIPIENT ELIGIBILITY UPDATE ERROR REPORT                   PAGE: 99,999
                                                      cycle date mmddccyy

RID                     NAME                                     SSN              BIRTH DATE          MESSAGE
                        ACTION TAKEN

999999999               XXXXXXXXXXXXXXX,  XXXXXXXXXXXX X         999999999        MM/DD/CCYY
                        XXXXXXXXXXXXXXXXXXXX
                        XXXXXXXXXXXXXXXXXXXXXXXXXX

999999999               XXXXXXXXXXXXXXX,  XXXXXXXXXXXX X         999999999        MM/DD/CCYY
                        XXXXXXXXXXXXXXXXXXXX
                        XXXXXXXXXXXXXXXXXXXXXXXXXX

999999999               XXXXXXXXXXXXXXX,  XXXXXXXXXXXX X         999999999        MM/DD/CCYY
                        XXXXXXXXXXXXXXXXXXXX
                        XXXXXXXXXXXXXXXXXXXXXXXXXX

                                          END OF REPORT
                                       NO DATA THIS REPORT
```

ELG-0006-D TPL Employer Updates From ICES

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0006-D		TPL Employer Updates From ICES

Description of Information

This report lists the recipients whose TPL Employer Information changed according to ICES.

Purpose

The purpose of the TPL Employer Updates From ICES is to provide EDS and IFSSA with information regarding the recipients whose TPL Employer information changed according to ICES. The information is not updated in the system.

Sort Sequence

- *Primary -* RID carrier number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Daily
IFSSA	CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

RID	Recipient identification number
Carrier Number	The number assigned to the recipient's carrier
Policy Number	The recipient's TPL policy number with his/her employer
Policy Holder SSN	The policy holder's social security number
Policy Holder Name	The name of the policy holder
Employer Name	The name of the policy holder's employer
Employer Address	The address of the policy holder's employer

```
REPORT:    ELG-0006-D                          IndianaAIM                          Run Date: 7/07/2000
PROCESS:   ELGJD010                  TPL EMPLOYER UPDATES FROM ICES               RUN TIME: 07:15:01
LOCATION:  HMKI8006                     CYCLE DATE:   07/06/2000                     PAGE NUM:

                      CARRIER NUMBER/          POLICY HOLDER SSN/                EMPLOYER NAME/
   RID                POLICY NUMBER            POLICY HOLDER NAME                EMPLOYER ADDRESS

100000949699          0014937                  614354799                         MASTER MANUFACTURING CO, INC
                      097-50-4512              CHARLES       ABSHAGEN            4703 O'HARA DR
                                                                                 425-1561
                                                                                 EVANSVILLE       IN
                                                                                 47701

100001495999          0014637                  311569762                         L S AYRES (SCOTTSDALE)
                      002856590                ANTOINETTE    ADAMS         M

100004810699          0014448                  005194499                         STARR STAFFING
                      007621326606049          LISA          ALEXANDER           464-4421

                                                                                 VALPARAISO       IN
                                                                                 46383

100005180399          0014448                  005194499                         STARR STAFFING
                      007621326606049          LISA          ALEXANDER           464-4421

                                                                                 VALPARAISO       IN
                                                                                 46383

100005274499          0014448                  005194499                         STARR STAFFING
                      007621326606049          LISA          ALEXANDER           464-4 61

                                    END OF REPORT
                                 NO DATA THIS REPORT
```

ELG-0007-D CSHCS Recipient Eligibility Update Error Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0007-D		CSHCS Recipient Eligibility Update Error Report

Description of Information

This report lists the attempted adds or updates that CSHCS transmitted to EDS but have not been accepted in the IndianaAIM database. A brief message explaining each error and a brief description of what action was taken are indicated on the report. These transactions must be corrected so the appropriate action is taken.

Purpose

The purpose of the CSHCS Recipient Eligibility Update Error Report is to provide EDS and CSHCS information regarding transactions were not accepted from CSHCS.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Daily
IFSSA	Paper/CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Field In Error	The field where an error is indicated on the CSHCS tape.
Field Value	The value passed from CSHCS
Message	A brief description of why an add or an update did not take place
Action Taken	The action that was taken on the record

Txn	Three character code sent to IndianaAIM to describe the transaction. Valid values: *ADD-*= add *UPD-*= update
RID	Recipient identification number
Name	Recipient's full name (last name, first name, MI)
SSN	Recipient's Social Security number
Birth Date	The recipient's date of birth in MM DD CCYY format

Report: ELG-0007-D Indiana*AIM* Run Date: MM/DD/CCYY
Process: Page Number:
Location: CSHCS RECIPIENT ELIGIBILITY UPDATE ERROR REPORT

FIELD IN ERROR	FIELD VALUE	MESSAGE	ACTION TAKEN
TXN UPD RID 120000000699	NAME FADI BERMUDA	SSN 308114939 BIRTH DATE 10-29-1992 CASE# 1929292929	WORKER W01233
CDE ISSUE RSN	s	ID CARD ISSUE REASON CODE IS INVALID	NO CARD
TXN UPD RID 120000000799	NAME FRANCOIS PAUL	SSN 308113339 BIRTH DATE 10-29-1989 CASE# 1444292929	WORKER W01243
CDE ISSUE RSN	s	ID CARD ISSUE REASON CODE IS INVALID	NO CARD

END OF REPORT
NO DATA THIS REPORT

ELG-0008-D CSHCS Provider Eligibility Update Error Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0008-D		CSHCS Provider Eligibility Update Error Report

Description of Information

This report lists the attempted provider eligibility adds or updates that CSHCS transmitted to EDS but have not been accepted in the IndianaAIM database. A brief message explaining each error and a brief description of what action was taken are indicated on the report. These transactions must be corrected so the appropriate action is taken.

Purpose

The purpose of the CSHCS Provider Eligibility Update Error Report is to provide EDS and CSHCS information regarding transactions that were not accepted.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Daily
IFSSA	Paper/CRLD	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Field In Error	The field where an error is indicated on the CSHCS tape.
Field Value	The value passed from CSHCS
Message	A brief description of why an add or an update did not take place
Action Taken	The action that was taken on the record
RID	Recipient identification number
Name	Recipient's full name (last name, first name, MI)

Report: ELG-0008-D Indiana*AIM* Run
Date: MM/DD/CCYY
Process: Page
Number:
Location:

CSHCS PROVIDER ELIGIBILITY UPDATE ERROR REPORT

FIELD IN ERROR	FIELD VALUE	MESSAGE	ACTION TAKEN
RID 120000000699 NAME	FADI BERMUDA		
PROVIDER NO.	583333333A	PROVIDER NAME IS INVALID	NO ADD

END OF REPORT
NO DATA THIS REPORT

ELG-0020-M Recipient Base Reconciliation Update

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0020-M		Recipient Base Reconciliation Update

Description of Information

The Recipient Base Reconciliation Update report is a paper copy of inserts and updates made to a recipient's record.

Purpose

The purpose of the Recipient Base Reconciliation Update report is to report all changes resulting from the file reconciliation between ICES and IndianaAIM.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

Recip ID	Recipient's 12character numeric identification number on the ICES Reconciliation Tape
Action	The action taken on the record (insert, update)
Insert	A recipient on file with ICES for whom no record exists in Indiana*AIM* .
Before Updt	The recipient's base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Delete	This field is not used
Last Name	The recipients last name
First Name	The recipients first name
MI	The recipients middle name
DOB	The recipients birth date (mmddyy)
DOD	The recipient death date (mmddyy)

Address Street 1	The recipients street address
Address Street 2	The recipients street address
City	The city of the recipient
ST	The recipients state
ZIP	The recipients nine digit ZIP code
Sex	The recipients gender (male or female)
Race	The recipients race
Lang	The recipient's primary language
Marital	The recipients marital status
Alien	The recipients alien status
Grant	The recipient's money grant status
County	Two-character numeric code describing the recipient's county in Indiana
Ward/Type	The recipient's ward status
SAK Case	This information is used to locate the specific record to be updated because a recipient may have more than one record.
SSN	Recipient's Social Security number

REPORT: Indiana*AIM* Run Date:
PROCESS: RECIPIENT BASE RECONCILIATION UPDATE REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	LAST NAME		DOB	ADDRESS STREET 1	CITY	SEX	LANG	
ALIEN	COUNTY	SAK/CASE						
ACTION	FIRST NAME	MI	DOD	ADDRESS STREET 2	ST	ZIP	RACE	MARITAL
GRANT	WARD/TYPE	SSN						
XXXXXXXXXXXX	XXXXXXXXXXXXXXXX		XX/XX/XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX			X
X	X	XX XXXXXXXX						
INSERT	XXXXXXXXXXXXX	X	XX/XX/XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXX		X
X	X	X XXXXXXXXXX						
XXXXXXXXXXXX	XXXXXXXXXXXXXXXX	X	XX/XX/XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX			X
X	X	XX XXXXXXXX						
BEFORE UPDT	XXXXXXXXXXXXX	X	X	XX/XX/XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXX	X	X	X
X	XXXXXXXXXX							
XXXXXXXXXXXX	XXXXXXXXXXXXXXXX	X	XX/XX/XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX			X
X	X	XX XXXXXXXX						
AFTER UPDT	XXXXXXXXXXXXX	X	X	XX/XX/XX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XX	XXXXXXXX	X	X
X	X	X XXXXXXXXX						

RECIPIENT BASE TOTALS	INSERTS	UPDATES
	999,999	999,999

ELG-0021-M Recipient Reconciliation MA Effective Dates

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0021-M		Recipient Reconciliation MA Effective Dates

Description of Information

The Recipient Reconciliation MA Effective Dates Report is a paper copy of inserts and updates made to a recipient's record.

Purpose of Report

The purpose of the Recipient Reconciliation MA Effective Date update is to report all changes to Medicaid start and stop dates resulting from the file reconciliation between ICES and Indiana*AIM*.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

Recip ID	Recipient's 12-character numeric identification number on the ICES reconciliation tape
Action	The action taken on the record (insert, update)
Insert	A recipient on file with ICES for whom no record exists in Indiana*AIM*.
Before Updt	The recipient's base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Program	This field indicate in which program the recipient is enrolled
Dte Effective	Indicates the *Start* dates of the listed program
Dte End	Indicates the *End* dates of the listed program
Status	This field normally is blank, unless a new segment was added in which case there is an **H indicator** in the field
Delete	This field is not used

REPORT: Indiana*AIM* Run Date:
PROCESS: RECIPIENT PROGRAM REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	ACTION	PROGRAM	DTE EFFECTIVE	DTE END	STATUS
XXXXXXXXXXXX	INSERT	XX	XX/XX/XX	XX/XX/XX	X
XXXXXXXXXXXX	BEFORE UPDT	XX	XX/XX/XX	XX/XX/XX	X
XXXXXXXXXXXX	AFTER UPDT	XX	XX/XX/XX	XX/XX/XX	X
XXXXXXXXXXXX	DELETE	XX	XX/XX/XX	XX/XX/XX	X

RECIPIENT PROGRAM TOTALS	INSERTS	UPDATES	DELETES
999,999	999,999	999,999	

ELG-0022-M Recipient AID Reconciliation Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0022-M		Recipient AID Reconciliation Report

Description of Information

The Recipient AID Reconciliation Report is a paper copy of inserts and updates made to a recipient's record

Purpose

The purpose of the Recipient AID Reconciliation Report is to report all the different aid category segment changes resulting from the file reconciliation between ICES and IndianaAIM.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA le	CRLD	1	Monthly

Detailed Field Definitions

Recip	Recipient's 12character numeric identification number on the ICES Reconciliation
Action	The action that was taken upon the record (insert update)
Insert	A recipient on file with ICES for whom no record exists in Indiana*AIM*
Before Updt	The recipient's base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Delete	This field is not used
Aid	The category of medical assistance for which the recipient is qualified
Dte Effective	Indicates the Start dates of the listed program
Dte End	Indicates the END dates of the listed program
Reason Stop	This field shows one of the following codes: O - Open Segment G - Death E - Case Closed for Regular circumstances
Status	This field is normally blank, unless a new segment is added, in which case a **H indicator appears** in the field

REPORT: Indiana*AIM* Run Date:
PROCESS: RECIPIENT AID REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	ACTION	AID	DTE EFFECTIVE	DTE END	REASON STOP	STATUS
XXXXXXXXXXXX	INSERT	XX	XX/XX/XX	XX/XX/XX	X	X
XXXXXXXXXXXX	BEFORE UPDT	XX	XX/XX/XX	XX/XX/XX	X	X
XXXXXXXXXXXX	AFTER UPDT	XX	XX/XX/XX	XX/XX/XX	X	X
XXXXXXXXXXXX	DELETE	XX	XX/XX/XX	XX/XX/XX	X	X

RECIPIENT AID TOTALS	INSERTS	UPDATES	DELETES
	999,999	999,999	999,999

ELG-0023-M Recipient Reconciliation Dual Aid Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0023-M		Recipient Reconciliation Dual Aid Report

Description of Information

The Recipient Reconciliation Dual Aid Report is a paper copy of inserts, updates, and deletes made to a recipient's record.

Purpose

The purpose of the Recipient Reconciliation Dual Aid report is to report all changes to Dual Aids resulting from the file reconciliation between ICES and Indiana*AIM*.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

Recip ID	Recipient's 12 character numeric identification number on the ICES Reconciliation Tape
Action	The action taken on the record (insert, update)
Insert	A recipient on file with ICES for whom no record exists in Indiana*AIM*.
Before Updt	The recipient's base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Delete	This field is used if the record has spaces for Dual Aid and the effective date on the incoming record is less than or equal to the data base, and incoming end date is greater than or equal to the data base, the record is be deleted
Dual Aid	One of the following codes appears in this field: J – SLB L – QMB LP – QMB Refugee
Dte Effective	Indicates the *Start* dates of the listed program
Dte End	Indicates the *End* dates of the listed program

REPORT: Indiana*AIM* Run Date:
PROCESS: RECIPIENT DUAL AID REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	ACTION	DUAL AID	DTE EFFECTIVE	DTE END
XXXXXXXXXXXX	INSERT	XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	BEFORE UPDT	XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	AFTER UPDT	XX	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	DELETE	XX	XX/XX/XX	XX/XX/XX

RECIPIENT DUAL AID TOTALS	INSERTS	UPDATES	DELETES
	999,999	999,999	999,999

ELG-0024-M Recipient Patient Liability Reconciliation Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0024-M		Recipient Patient Liability Reconciliation Report

Description of Information

The Recipient Patient Liability Reconciliation Report is a paper copy of inserts, updates, and deletes made to a recipient's record.

Purpose

The purpose of the Recipient Patient Liability Reconciliation Report is to report all changes to recipient patient liability as a result of file reconciliation between ICES and Indiana*AIM*.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

Recip ID	Recipient's 12 character numeric identification number on the ICES Reconciliation Tape
Action	The action taken on the record (insert Update)
Insert	A recipient on file with ICES for whom no record exists in Indiana*AIM*.
Delete	This field is used if the Patient Liability amount is zero and the effective date on the incoming record is less than or equal to the date on the data base, and the incoming records end date is greater than or equal to the database, the record is deleted
Before Updt	The recipients' base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Amt.	The actual dollar amount
Dte Effective	Indicates the *Start* dates of the listed program
Dte End	Indicates the *End* dates of the listed program

REPORT: Indiana*AIM* Run Date:
PROCESS: PATIENT LIABILITY REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	ACTION	AMT	DTE EFFECTIVE	DTE END
XXXXXXXXXXXX	INSERT	99,999.99	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	BEFORE UPDT	99,999.99	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	AFTER UPDT	99,999.99	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	DELETE	99,999.99	XX/XX/XX	XX/XX/XX

PATIENT LIABILITY TOTALS	INSERTS	UPDATES	DELETES
999,999	999,999	999,999	

ELG-0025-M Recipient Reconciliation Spenddown Status Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0025-M		Recipient Reconciliation Spenddown Status Report

Description of Information

The Recipient Reconciliation Spenddown Status Report is a paper copy of inserts, updates, and deletes made to a recipient's record.

Purpose

The purpose of the Recipient Reconciliation Spend-down Status report is to report all changes to recipient spend-down status as a result of file reconciliation between ICES and Indiana*AIM*.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

Recip ID	Recipient's 12 character numeric identification number on the ICES reconciliation tape
Action	The action taken on the record (insert, update)
Insert	A recipient on file with ICES for which no record exists in Indiana*AIM*
Before Updt	The recipient's base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Delete	This field is used if the spenddown flag is ***N*** and the effective date on the incoming record is less than or equal to the date on the data base, and the incoming records end date is greater than or equal to the database, the record is deleted
SAK Spend Liab	This information is used to locate the specific record to update since a recipient may have more than one record
Dte Effective	Indicates the *Start* dates of the listed program
Dte End	Indicates the *End* dates of the listed program

REPORT: Indiana*AIM* Run Date:
PROCESS: SPENDDOWN STATUS REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	ACTION	SAK SPEND LIAB	DTE EFFECTIVE	DTE END
XXXXXXXXXXXX	INSERT	XXXXXXXX	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	BEFORE UPDT	XXXXXXXX	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	AFTER UPDT	XXXXXXXX	XX/XX/XX	XX/XX/XX
XXXXXXXXXXXX	DELETE	XXXXXXXX	XX/XX/XX	XX/XX/XX

SPENDDOWN LIABILITY TOTALS	INSERTS	UPDATES	DELETES
	999,999	999,999	999,999

ELG-0026-M Recipient Reconciliation Spenddown Met Date Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0026-M		Recipient Reconciliation Spenddown Met Date Report

Description of Information

The Recipient Reconciliation Spenddown Met Date report is a paper copy of inserts, update, and deletes made to a recipient's record.

Purpose

The purpose of the Recipient Reconciliation Spenddown Met Date report is to show the date that spenddown was met according to the file reconciliation between ICES and Indiana*AIM*.

Sort Sequence

- *Primary -* RID number

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

Recip ID	Recipient's 12-character numeric identification number on the ICES reconciliation tape
Action	The action taken on the record (insert, update)
Insert	A recipient on file with ICES for whom no record exists in Indiana*AIM*.
Before Updt	The recipient's base data prior to the ICES update to Indiana*AIM*
After Updt	The recipient's base data after the ICES update to Indiana*AIM*
Delete	This field is used if the spenddown flag is N and the effective date on the incoming record is less than or equal to the date on the database, and the incoming records end date is greater than or equal to the database, the record is deleted
SAK Spend Liab	This information is used to locate the specific record to be updated since because a recipient may have more than one record
Dte Received	Indicates the spenddown met date

REPORT: Indiana*AIM* Run Date:
PROCESS: SPENDDOWN MET DATE REPORT DRAFT RUN TIME:
LOCATION: PAGE NUM:

RECIP ID	ACTION	SAK SPEND LIAB	DTE RECEIVED
XXXXXXXXXXXX	INSERT	XXXXXXXX	XX/XX/XX
XXXXXXXXXXXX	BEFORE UPDT	XXXXXXXX	XX/XX/XX
XXXXXXXXXXXX	AFTER UPDT	XXXXXXXX	XX/XX/XX
XXXXXXXXXXXX	DELETE	XXXXXXXX	XX/XX/XX

SPENDDOWN PAYMENT TOTALS	INSERTS	UPDATES	DELETES
	999,999	999,999	999,999

ELG-0027-M ICES Reconciliation TPL Policy Holder Audit Trail Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0027-M	ELGJM300	ICES Reconciliation TPL Policy Holder Audit Trail Report

Description of Information

The ICES Reconciliation TPL policyholder audit trail report is a list of inserts, updates, and deletes made to a recipient's record.

Purpose

The purpose of the ICES Reconciliation TPL policy holder audit trail report is to report all changes to TPL Policy holder information resulting from the file reconciliation between ICES and IndianaAIM. The last line in the report shows how many inserts, updates, and deletes were made.

Sort Sequence

- *Primary -* SAK policy holder

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
IFSSA	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Action	The action taken on the record (insert update)
SAK Policy Holder	The SAK assigned to the policy holder
SSN	Policy holder's Social Security number
Name Last	The policy holders last name

First Name	The policy holders first name
MI	The policy holders middle initial
Address Street 1	The policy holders street address
Address Street 2	The policy holders street address
City	The policy holders city
ST	The policy holders state
ZIP	The policy holders nine digit ZIP code

```
REPORT:   ELG-0027-M                          IndianaAIM                        RUN DATE: 07/22/2000
             PROCESS:  ELGJM300     ICES RECONCILIATION TPL POLICY HOLDER AUDIT TRAIL REPORT    RUN TIME:   14:03:53
             LOCATION: RCNP0080                                                                PAGE:             1

ACTION     SAK_POLICY_HOLDER SSN       NAME LAST       FIRST NAME  MI ADDRESS STREET 1      CITY            ST  ZIP
                                                                      ADDRESS STREET 2

BEFORE UPDT      22129                 LIPSCOMB        HAROLD

AFTER UPDT       22129        316267858 LIPSCOMB        HAROLD

BEFORE UPDT      22129                 HAROLD          LIPSCOMB

AFTER UPDT       22129        316267858 LIPSCOMB        HAROLD

INSERT           3606121      000000000 MCCLORY         EDWARD

INSERT           3606122      765754599 VANHOOSE        KEITH

INSERT           3606123      041467099 BLUMENHORST     KRIS       A

INSERT           3606124      998987099 ROSS            MARY       E

BEFORE UPDT      3558771               ALLEN           LAREW

AFTER UPDT       3558771      308095044 ALLEN           LAREW      E

BEFORE UPDT      3558771               LAREW           ALLEN

AFTER UPDT       3558771      308095044 ALLEN           LAREW      E

INSERT           3606125      783461199 BOYD            JIMMIE     L

   TPL POLICY HOLDER TOTALS
   INSERTS    UPDATES     DELETES
         5          4           0
                                                   END OF REPORT
                                                NO DATA THIS REPORT
```

ELG-0028-M ICES Reconciliation TPL Resource Audit Trail Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0028-M	ELGJM300	ICES Reconciliation TPL Resource Audit Trail Report

Description of Information

The ICES Reconciliation TPL Resource audit trail report is a list of inserts, updates, and deletes made to a recipient's record.

Purpose

The purpose of the ICES Reconciliation TPL resource audit trail report is to report all changes to TPL Resource information resulting from the file reconciliation between ICES and Indiana*AIM*. The last line in the report shows how many inserts, updates, and deletes were made.

Sort Sequence

- *Primary -* RID

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
IFSSA	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Recip ID	The recipient identification number
Action	The action taken on the record (insert, update).
Num Group	The group number of the insurance company
Num TPL Policy	The policy number of the insurance company
Carrier	The number assigned to a specific insurance company

Dte Effective	The effective date of the insurance coverage
Dte End	The last date of the insurance coverage
Relationship	The relationship code of the policy holder
Coverage Xref Codes	Coverage type code for a TPL resource
Court Ordered	This code identifies the type of court ordered insurance that must be provided by an absent parent

REPORT: ELG-0028-M
PROCESS: ELGJM300
LOCATION: RCNS0100

Indiana*AIM*
ICES RECONCILIATION TPL RESOURCE AUDIT TRAIL REPORT

RUN DATE: 07/22/2000
RUN TIME: 14:03:53
PAGE: 1

RECIP ID	ACTION	NUM TPL POLICY	CARRIER	DTE EFFECTIVE	DTE END	NUM GROUP RELATIONSHIP	COVERAGE XREF CODES	COURT ORDERED
	BEFORE UPDT					A		
100312886399	AFTER UPDT	104 R00832999	0003228	01/01/78	12/31/99	A	ABCDF	
	BEFORE UPDT					G		
100312886399	AFTER UPDT	104 R00832999	0003228	01/01/78	12/31/99	A	ABCDF	
100496596699	INSERT	8011	0008979	01/01/00	12/31/99	C	ABCE	
	BEFORE UPDT				12/31/99			
100665436099	AFTER UPDT	456715-58-000 314485411	0003668	01/01/99	05/31/00	C	EQ	
100887916399	INSERT	175578 304360771	0002045	01/01/97	12/31/99	G	ABCEGHOP	
	BEFORE UPDT					C		

TPL RESOURCE TOTALS

INSERTS	UPDATES	DELETES
15	10	0

END OF REPORT
NO DATA THIS REPORT

ELG-0030-D Medicaid Card Reissue – New Linked RID Notification

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0030-D	ELGJD018	Medicaid Card Reissue – New Linked RID Notification

Description of Information

When two or more existing RIDs are linked, a new Medicaid card may be issued. A notice is sent to the recipient to inform him/her which card to use, and which RID number is valid.

Purpose

The purpose of the Medicaid Card Reissue – New Linked RID Notification Report is to inform the recipient which card and RID number is valid.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Daily

Balancing Procedures

None

CSR Numbers

None

Detailed Field Definitions

Name	The names in Last, First, MI order, as carried on the recipient base screen, of the recipient whose RID numbers are linked.
Address	Address of the Medicaid recipient.
RID Number	A 12-byte numeric field which represents the valid recipient identification number.
Date	The date the notice was produced or sent (mm/dd/ccyy).
Name	Last, First, MI
Address	City, State, ZIP Code

Concerning your Plastic Hoosier Healthwise Identification Card

Effective immediately, begin using the Hoosier Healthwise ID Card with the identification number of XXXXXXXXXXX on the front. If the card with this number is not in your possession today, or you have not received this card within 5 days of receiving of this letter, please contact your caseworker. Please destroy all previously issued cards that you have in your possession.

If you present your old card(s) to your doctor, pharmacy or other provider of service, the provider will be notified that the card is invalid.

If you are enrolled in the Hoosier Healthwise Program, your new identification card should not affect your enrollment in Hoosier Healthwise. If you have any questions, call the Hoosier Healthwise Recipient Enrollment line at 1-800-246-2224.

Your cooperation in this matter will ensure that you receive services without any interruption in your coverage.

Date 99/99/9999

Elg D0030

ELG-0410-M Aid Categories With Age/Time Limits

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-0410-M		AID Categories With Age/Time Limits

Description of Information

This report lists the recipients whose eligibility exceeded either the age or time limits for the following programs:

MA 1 Medicaid for children under 19 who meet AFDC income standards

MA 2 Medicaid for children ages 6-19

MA 3 Medicaid for Wards under age 18

MA 4 Medicaid for IV-E Foster Care Children under age 18

MA 8 Medicaid for Children, under 18, receiving adoption assistance

MA 9 Medicaid for Children age 1 through 18 (CHIP I)

MA 10 Package C, Children under age 19 (CHIP II)

MA E Extended Medicaid for pregnant women (Medicaid Effective Date one year or more in the past)

MA F Transitional Medical Assistance (TMA) 1year program: (Medicaid Effective Date 1 year or more in the past)

MA M Full range Medicaid for pregnant women 1 year program: (Medicaid Effective Date 1 year or more in the past)

MA N Limited Medicaid for pregnant women, 1 year program (Medicaid Effective Date 1 year or more in the past)

MA O Medicaid for inpatient psychiatry facility patients under age 21

MA X Medicaid for newborn children under the age of 1 year

MA Y Medicaid for children under the age of 1 year

MA Z Medicaid for children under the age of 6 years

The last field on the report shows the number of days the recipient's eligibility over the age or time limit.

Purpose

The purpose of the Aid Categories with Age/Time Limits is to provide EDS and IFSSA with information regarding the number of recipients whose eligibility exceeded the pre-set limits.

Sort Sequence

- *Primary -* County number, ascending (1-92)
- *Secondary -* Program

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
IFSSA	CRLD	1	Monthly

Balancing Procedures

None

CSR Numbers

IN012507

Detailed Field Definitions

Case Worker ID	Six alpha character numeric caseworker number
Aid Category	The category of medical assistance for which the recipient is qualified
RID	Recipient identification number
Name	Recipient's full name (first name, last name, MI)
Birth Date	The recipient's date of birth in MM/DD/CCYY format
Case Number	Ten numeric characters assigned by ICES to the recipient (when available)
Telephone Number	Recipient telephone number
Dte Effective	Indicates the Start dates of the listed program
Days Lapsed	Indicates the number of days the age or time limit that the recipient's eligibility exceeded.

REPORT: ELG-0410-M Indiana*AIM* RUN DATE: 06/01/2000
PROCESS: ELGJM410 AID CATEGORIES WITH AGE/TIME LIMITS RUN TIME: 20:04
LOCATION: ELGP410A CYCLE DATE: 06/01/2000 PAGE NUM: 1

CASE WORKER ID	AID CATEGORY		RID	LAST NAME	FIRST NAME	MI	BIRTH DATE	CASE NUMBER	TELEPHONE NUMBER	EFFECTIVE DATE	DAYS LAPSED
COUNTY 01 ADAMS											
W49206	MA	4	100648467799	CUNNINGHAM	LAMONT		19820216	1007865478	3179254231	19951101	106
W01028	MA	F	102420083299	SULOVIC	ARNELA		19890923	1013145220	2195898142	19990501	31
W01028	MA	F	102420084099	SULOVIC	AMIRA		19591226	1013145220	2195898142	19990501	31
W01024	MA	X	102639252099	MENDEZ	ALLISON	M	19990531	1000926459	2197247202	19990531	1
W01028	MA	X	102625327699	CRISPEN	CHRISTOPHER	S	19990410	1013981822	2193687105	19990410	52
W01028	MA	Z	101721992299	MYERS	JACOB	D	19940427	1000257855	2197244082	19990201	35
COUNTY 02 ALLEN											
W02911	MA	2	102122415799	HULL	MARY	K	19800322	1010345799	2194228418	19971001	71
W02823	MA	2	101502547999	MENZIE	DEVON	M	19940604	1003808233	2194565137	20000601	2
W02911	MA	2	102817915699	ABON	RICO	M	19940602	1017213164	2193730275	20000101	0
W02706	MA	4	100405047099	ROBERSON	SHONTEL	R	19820209	1016722504	2197446755	20000101	113
W49205	MA	4	100353789999	NIEVES	JUAN	J	19810902	1005270242	2197453322	19940901	273
W02115	MA	F	101744722699	CONSER	MICHELLE	A	19690307	1002880571	2194908105	19990501	31
W02801	MA	F	100349781399	NEELY	LORA	L	19680317	1000381465	2194260343	19990401	61
W02827	MA	F	102228677599	WALLACE	RACHEL	A	19770503	1011124870	2194830916	19990401	61

END OF REPORT
NO DATA THIS REPORT

ELG-9001-M Explanation of Medicaid Benefits Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-9001-M	ELGJM010	Explanation of Medicaid Benefits Report

Description of Information

The Explanation of Medicaid Benefits (EOMB) letter (ELG-9001-M) is a system generated letter sent to a random one percent of the Medicaid recipient population. EOMBs may be selected by the following health programs: Medicaid, 590, and EPSDT. EOMBs also may be selected by the requested provider number. The address of the recipient to whom an EOMB is sent is printed on the back of each page of the report. The address is be located 3/4 of an inch from the bottom and 4 1/2 inches from the left side of each page, of the report.

Purpose

Explanation of Medicaid Benefits (EOMB) letter (ELG-9001-M) is used to assist in the identification of potential program fraud and help conserve Medicaid funds provided for the Medicaid recipients.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
Recipients (up to 1 percent of the recipient population)	Paper/CRLD	1	Monthly

Detailed Field Definitions

Recipient Name	Recipient first name, middle initial, and last name
RID Number	Recipient's identification number
Provider	The name of the provider who billed the services
Dates Of Service From To	The date range during which services were rendered by a specific provider
Service Description	A brief description of the service rendered
Claim Number	The recipient claim number
Amount Allowed	The dollar amount allowed for a specific claim
Medicaid Allowed	The total dollar amount allowed by Medicaid for all listed claims

EXPLANATION OF MEDICAID BENEFITS

This is not a bill. The Explanation of Medicaid Benefits (EOMB) listings are now being produced on a monthly basis for a randomly selected percentage of the Medicaid recipient population, therefore you may or may not receive another one.

Listed below are the services Medicaid paid for you on the following dates. If you did not receive all of these services, please write a brief note on this form and return it to:

HCE

ATTN: Surveillance and Utilization Review

P.O. Box 68754, Indianapolis, IN 46268-8764

or

call 1-317-488-5045 or 1-800-457-4515

Your cooperation in reviewing and responding to this information will assist in the identification of potential program fraud and help conserve Medicaid funds provided for you benefit.

EXPLANATION OF MEDICAID BENEFITS PAID LAST MONTH

```
RECIPIENT NAME:    XXXXXXXXXXXX                                RID#:  999999999999


PROVIDER          DATES OF SERVICE      SERVICE DESCRIPTION          CLAIM         ALLOWED
                    FROM       TO                                    NUMBER        AMOUNT

XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99
XXXXXXXXXXXXXXXXXX 99/99/99  99/99/99    XXXXXXXXXXXXXXXXXXXXXXXXXXX   XXXXXXXXXXX   99,999.99

                                                                  MEDICAID ALLOWED   9,999,999



                                      * * END OF REPORT * *

                                     * * NO DATA THIS RUN * *
```

ELG-9002-M Summary of Recipient EOMBs

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-9002-M	ELG-9002-M	Summary of Recipient EOMBs

Note: Systems is reviewing the report number – ELG-9002-M vs. ELG-0002-M. Dec'00

Description of Information

The report lists the total number of EOMBs produced, the date they were produced, the RID that had an EOMB produced, the number of claims reported for each recipient, and the total dollar amount that was reported on the EOMB for each recipient.

Purpose

The Summary of Recipient EOMBs report is used by EDS and the State to identify the number of EOMBs produced.

Sort Sequence

- *Primary -* Recipient ID

Distribution

To	Media	Copies	Frequency
EDS	Paper/CRLD	1	Monthly

Detailed Field Definitions

RID	The recipient identification number
Num Of Claims Reported	The number of claims were reported on the EOMB for the recipient
Total Dollars	The total dollar amount that was reported on the EOMB for the recipient
Grand Total	The totals for: number of all services, number of claims, and total dollar amount reported on the EOMB.
Number Of EOMBs Generated	The number of Explanation of Medical Benefits forms generated
Date Generated	The date that the EOMBs were generated

REPORT: ELG-9002-M
PROCESS:
LOCATION:

INDIANA*AIM* RUN DATE: MM/DD/CCYY
PAGE:

SUMMARY OF RECIPIENT EOMBS

RID	NUM OF CLAIM REPORTED	TOTAL D0LLARS
999999999999	9,999	999,999.99
999999999999	9,999	999,999.99
999999999999	9,999	999,999.99
999999999999	9,999	999,999.99
999999999999	9,999	999,999.99
GRAND TOTAL:	9,999,999	9,999,999.99

NUMBER OF EOMBS GENERATED 9,999
DATE GENERATED MM/DD/CCYY

* * END OF REPORT * *

* * NO DATA THIS RUN * *

ELG-9003-D Recipient ID Cards

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-9003-D		Recipient ID Cards

***This report is currently in SME review. 12/27/00*

ELG-MANUAL-M EOMB Inquiry Monthly Report

Functional Area	Report Number	Job Name	Report Title
Eligibility	ELG-MANUAL-M		EOMB Inquiry Monthly Report

Description of Information

The EOMB Inquiry Report is a monthly manual report which informs the State of the number of claims questioned, the percentage of claims questioned, and the dollar amount of claims questioned.

Purpose

The EOMB Inquiry Report is used by EDS and the State to identify the number of claims questioned, the percentage of claims questioned, and the dollar amount of claims questioned.

Sort Sequence

N/A

Distribution

To	Media	Copies	Frequency
EDS	Paper	1	Monthly
FSSA	Paper	1	Monthly

Detailed Field Definitions

Claims Questioned	The number of claims questioned from the mailed EOMBs
Percentage Of Claims Questioned	The percentage of claims questioned from the mailed EOMBs
Dollar Amount Of Claims Questioned	The total dollar amount of claims questioned from the mailed EOMBs

REPORT: ELG-9002-M INDIANA*AIM* RUN DATE: MM/DD/CCYY
PROCESS: PAGE:
LOCATION:

EOMB INQUIRY MONTHLY REPORT

MONTH OF MM/DD/CCYY

CLAIM QUESTIONED:	999
PERCENTAGE OF CLAIM QUESTIONED	999
DOLLAR AMOUNT OF CLAIM QUESTIONED	9,999,999.99

* * END OF REPORT * *

* * NO DATA THIS RUN * *

Section 12: EPS Reports

EPS-0004-M EPSDT Summary of Notices Sent

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-0004-M		EPSDT Summary of Notices Sent

Description of Information

The Summary of EPSDT Notices Sent (EPS-0004-M) report provides a monthly listing of recipients who received an EPSDT letter for one or more of the following notification categories: newly eligible, non-participating, re-screening, or pregnancy. The report details the recipient's name, RID number, address, and date of birth. It also provides the recipient's PMP name and PMP phone number, if applicable. As of January 1, 2000, this report includes Package C data.

The number of notifications sent in each notification category and county is totaled at the end of each notification section. The total of notifications sent, by notification category for the state, is calculated at the end of the report. Page breaks occur after each notification category within, each county. Control breaks and page breaks occur at each new county listing.

The notification categories are defined below.

Newly Eligible — A pamphlet is sent to the recipients who are new to Medicaid and are under 21 years of age as well as to those new to Package C and under 18 years of age. This also includes recipients whose eligibility was reinstated.

Non-Participating — A pamphlet is sent to the recipients who have received the newly eligible notification, but have no screening claim history for 12 consecutive months.

Rescreening — A re-screening notification letter is sent to every recipient who has an upcoming screening according to age and the published periodicity schedule. The recipient is to receive this letter the month before the birthday requiring a screening.

Pregnant Women — The pregnant women letter is sent to every recipient in the SOBRA (ICES Aid Categories MAE, MAM, MAN, MAP, MAMP, MANP, MAPP) aid category. Each recipient receives this letter only once during a pregnancy.

> February 1995 month end was the first scheduled delivery of the Summary of EPSDT Notices Sent Report (EPS-004-M), containing October 1994 data.

Purpose

The Summary of EPSDT Notices Sent Report (EPS-0004-M) is used by the OMPP to verify that EPSDT notification letters are sent to eligible recipients and used in conjunction with the Health Department to provide outreach services.

Sort Sequence

- *Primary -* County
- *Secondary -* Notification type
- *Tertiary -* Recipient last name, first name, middle initial

Distribution

To	Media	Copies	Frequency
EDS	CRLD	1	Monthly
FSSA	CRLD	1	Monthly

Detailed Field Definitions

County	This field displays the name of the county where the recipient resides.
Notification Sent	This field displays the notification sent category. The three categories include newly eligible, pregnant women, and re-screening.
Recipient Name	This field displays the recipient's last name, first name, and middle initial.
RID Number	This field displays the recipient's identification number.
Recipient Address	This field displays the recipient's address.
Date Of Birth	This field displays the recipient's date of birth.
PMP Name	This field displays the recipient's Primary Medical Provider, if applicable. Only those recipients linked to PCCM or MCO have a PMP. If the PMP is a member of a group, the group service location phone number reports.
State Totals	This field displays the total number of notifications sent, by category, for the state.

```
    REPORT:  EPS-0004-M                                                       IndianaAIM                       RUN DATE:  MM/DD/CCYY
    PROCESS:                                                                                                        RUN TIME:  MM:HH
    LOCATION:                                                        EPSDT SUMMARY OF NOTICES SENT             PAGE:          99,999
                                                                  PERIOD:  MM/DD/YY THROUGH MM/DD/YY
                                                                         COUNTY:  XXXXXXXXXXX

    NOTIFICATION SENT:  NEWLY ELIGIBLE

RECIPIENT NAME                        RECIPIENT                           DATE OF         PMP NAME
RID NUMBER                            ADDRESS                             BIRTH           PMP PHONE NUMBER

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.         XXXXXXXXXXXXXXXXXXXXXXXXXXXX        MM/DD/YY    XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                              XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    999 999 9999
                                          XXXXXXXXXXXXX, XX 99999 9999

    COUNTY TOTAL:  999,999
```

```
REPORT:  EPS-0004-M                                                       IndianaAIM                       RUN DATE:  MM/DD/CCYY
PROCESS:                                                                                                        RUN TIME:  MM:HH
LOCATION:                                                       EPSDT SUMMARY OF NOTICES SENT               PAGE:         99,999
                                                              PERIOD:  MM/DD/YY THROUGH MM/DD/YY
                                                                     COUNTY:  XXXXXXXXXXX

NOTIFICATION SENT:  PREGNANT WOMEN

                   RECIPIENT NAME                        RECIPIENT                         DATE OF    PMP NAME
                   RID NUMBER                            ADDRESS                           BIRTH      PMP PHONE NUMBER

                   XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY  XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
                   XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX              999 999 9999
                                                            XXXXXXXXXXXXX, XX 99999 9999

                   XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY  XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
                   XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX              999 999 9999
                                                            XXXXXXXXXXXXX, XX 99999 9999

                   XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY  XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
                   XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX              999 999 9999
                                                            XXXXXXXXXXXXX, XX 99999 9999

                   XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY  XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
                   XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX              999 999 9999
                                                            XXXXXXXXXXXXX, XX 99999 9999

                   XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY  XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
                   XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX              999 999 9999
                                                            XXXXXXXXXXXXX, XX 99999 9999

                   XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY  XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
                   XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX              999 999 9999
                                                            XXXXXXXXXXXXX, XX 99999 9999

                                                                  COUNTY TOTAL:  999,999

                                                                   * * END OF REPORT * *

                                                                 * * NO DATA THIS RUN * *
```

```
 REPORT:  EPS-0004-M                                                                IndianaAIM                                              RUN
                                                            DATE:  MM/DD/CCYY
 PROCESS:                                                                                                                                   RUN
 TIME:  MM:HH
 LOCATION:                                                                EPSDT SUMMARY OF NOTICES SENT
                                                                              PAGE:          99,999
                                                                      PERIOD:  MM/DD/YY THROUGH MM/DD/YY
                                                                              COUNTY:  XXXXXXXXXXX
 NOTIFICATION SENT:  RESCREENING

RECIPIENT NAME                        RECIPIENT                         DATE OF    PMP NAME
RID NUMBER                            ADDRESS                           BIRTH      PMP PHONE NUMBER

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

XXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.        XXXXXXXXXXXXXXXXXXXXXXXXXXXX    MM/DD/YY XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX X.
XXXXXXXXXXXX                             XXXXXXXXXXXXXXXXXXXXXXXXXXXX             999 999 9999
                                         XXXXXXXXXXXXX, XX 99999 9999

                    COUNTY TOTAL:  999,999

                    STATE TOTALS:  NEWLY ELIGIBLE:    999,999
                                   PREGNANT WOMEN:    999,999
                                   RESCREENING:       999,999
```

EPS-0007-Q Vaccines for Children Program Provider Utilization – Medicaid

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-0007-Q		Vaccines for Children Program Provider Utilization – Medicaid

Description of Information

The Vaccines for Children Program Provider Utilization Report – Medicaid (EPS-0007-Q) details the quantity and cost of immunizations provided to children 18 years of age and under. This quarterly report lists the number of vaccinations administered by a particular provider.

Totals per county are listed at the end of the report followed by the statewide totals. Page breaks occur at the end of each county.

Production reporting captures claims paid in a particular quarter and is specific to the quarter analyzed. EPS-0007-Q is scheduled to run at the end of each quarter after the partition of claims paid for that same quarter is compiled.

Purpose

The Vaccines for Children Program Provider Utilization Report – Medicaid (EPS-0007-Q) is used by the State to ensure utilization requirements are followed by providers.

Sort Sequence

- *Primary* - County
- *Secondary* - Provider

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Quarterly
IFSSA	CRLD/Paper	1	Quarterly

Detailed Field Definitions

County	The name of the county.
Provider Name	The name of the provider as last name, first name and middle initial.
Medicaid Number	The provider's Medicaid number.
#90700	The number of dosages of DTAP vaccine administered by the provider. This data is obtained from paid claims submitted by the provider for the monthly reporting period.

$90700	The dollar amount equal to member's reimbursement for paid claims for DTAP vaccinations submitted by the provider for the monthly reporting period.
#90721	The number dosages of DTAP/HIB immunizations administered by the provider. This data is obtained from paid claims for the monthly reporting period submitted by the provider.
$90721	The dollar amount equal to member's reimbursement for paid claims for the DTAP/HIB vaccinations for the monthly reporting period submitted by the provider.
$90702	The dollar amount equal to member's reimbursement for paid claims for Td/PED vaccinations for the monthly reporting period submitted by the provider.
#90718	The number of dosages of Td/ADULT (Tetanus & Diphtheria) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90718	The dollar amount equal to member's reimbursement for paid claims for Td/ADULT vaccinations for the monthly reporting period submitted by the provider.
$90737	The dollar amount equal to member's reimbursement for paid claims for HIB vaccinations for the monthly reporting period submitted by the provider.
#90712	The number of dosages of OPV (Oral Polio) immunizations administered by the provider. This data comes; from paid claims for the monthly reporting period submitted by the provider.
$90712	The dollar amount equal to member's reimbursement for paid claims for OPV vaccinations for the monthly reporting period submitted by the provider.
$90713	The dollar amount equal to member's reimbursement for paid claims for IPV vaccinations for the monthly reporting period submitted by the provider.
#90707	The number of dosages of MMR (Measles, Mumps, Rubella) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90707	The dollar amount equal to member's reimbursement for paid claims for MMR (Measles, Mumps, Rubella) vaccinations for the monthly reporting period submitted by the provider.
#90744	The number of dosages of HBP (Hepatitis B Pediatric) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
#90745	The number of dosages of HepB-Adol (Hepatitis B Adolescent/High Risk) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.

$90745	The dollar amount equal to member's reimbursement for paid claims for HepB-Adol vaccinations for the monthly reporting period submitted by the provider.
#90716	The number of dosages of Varicella (Chicken Pox) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90716	The dollar amount equal to member's reimbursement for paid claims for Varicella (Chicken Pox) vaccinations for the monthly reporting period submitted by the provider.
#90742	The number of dosages of HBIG (Hepatitis B Immune Globulin) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90742	The dollar amount equal to member's reimbursement for paid claims for HBIG (Hepatitis B Immune Globulin) vaccinations for the monthly reporting period submitted by the provider.
#90748 Also Temporary Procedure Code: Q0158	The number of dosages of Hep B Ped +HIB (Hepatitis B Pediatric and Haemophillus Influenza B) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90748 Also Temporary Procedure Code: Q0158	The dollar amount equal to member's reimbursement for paid claims for Hep B Ped + HIB (Hepatitis B Pediatric & Haemophillus Influenza B) vaccinations for the monthly reporting period submitted by the provider.
State Totals	The total number of all VFC vaccines provided by every county and the total dollar amount reimbursed for each VFC vaccine for the state.

```
    REPORT:   EPS-0007-Q                                                      IndianaAIM                      RUN DATE:  MM/DD/CCYY
    PROGRAM:  XXXXXXXXX                                                                                            RUN TIME:  HH:MM
    LOCATION: XXXXXXXXX                                              VACCINE FOR CHILDREN PROGRAM              PAGE NUMBER:  99,999
                                                                   PROVIDER UTILIZATION - MEDICAID
                                                                  PERIOD MM/DD/YY THROUGH MM/DD/YY

    COUNTY:   XXXXXXXXXXX

               PROVIDER NAME                  #90700      #90702     #90737      #90713     #90744      #90716     #90748
              MEDICAID NUMBER                 $90700      $90702     $90737      $90713     $90744      $90716     $90748
                                              #90721      #90718     #90712      #90707     #90745      #90742     #Q0158
                                              $90721      $90718     $90712      $90707     $90745      $90742     $Q0158

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X    9,999      9,999       9,999      9,999       9,999      9,999       9,999
999999999X                                   999,999     999,999    999,999     999,999    999,999     999,999    999,999
                                               9,999      9,999       9,999      9,999       9,999      9,999       9,999
                                             999,999      999,999    999,999    999,999    999,999     999,999   9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X    9,999      9,999       9,999      9,999       9,999      9,999       9,999
999999999X                                   999,999     999,999    999,999     999,999    999,999     999,999    999,999
                                               9,999      9,999       9,999      9,999       9,999      9,999       9,999
                                             999,999      999,999    999,999    999,999    999,999     999,999   9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X    9,999      9,999       9,999      9,999       9,999      9,999       9,999
999999999X                                   999,999     999,999    999,999     999,999    999,999     999,999    999,999
                                               9,999      9,999       9,999      9,999       9,999      9,999       9,999
                                             999,999      999,999    999,999    999,999    999,999     999,999   9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X    9,999      9,999       9,999      9,999       9,999      9,999       9,999
999999999X                                   999,999     999,999    999,999     999,999    999,999     999,999    999,999
                                               9,999      9,999       9,999      9,999       9,999      9,999       9,999
                                             999,999      999,999    999,999    999,999    999,999     999,999   9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X    9,999      9,999       9,999      9,999       9,999      9,999       9,999
999999999X                                   999,999     999,999    999,999     999,999    999,999     999,999    999,999
                                               9,999      9,999       9,999      9,999       9,999      9,999       9,999
                                             999,999      999,999    999,999    999,999    999,999     999,999   9,999,999
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REPORT:   EPS-0007-Q                                                      IndianaAIM                      RUN DATE:  MM/DD/CCYY
PROGRAM:  XXXXXXXXX                                                                                            RUN TIME:  HH:MM
LOCATION: XXXXXXXXX                                              VACCINE FOR CHILDREN PROGRAM              PAGE NUMBER:  99,999
                                                               PROVIDER UTILIZATION - MEDICAID
                                                                   COUNTY and STATE TOTALS
                                                               PERIOD MM/DD/YY THROUGH MM/DD/YY


       COUNTY                    #90700        #90702       #90737        #90713       #90744        #90716       #90748
                                 $90700        $90702       $90737        $90713       $90744        $90716       $90748
                                 #90721        #90718       #90712        #90707       #90745        #90742       #Q0158
                                 $90721        $90718       $90712        $90707       $90745        $90742       $Q0158

    XXXXXXXXXXX                  999,999       999,999      999,999       999,999      999,999       999,999      999,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                                 999,999       999,999      999,999       999,999      999,999       999,999       9,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

    XXXXXXXXXXX                  999,999       999,999      999,999       999,999      999,999       999,999      999,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                                 999,999       999,999      999,999       999,999      999,999       999,999       9,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

    XXXXXXXXXXX                  999,999       999,999      999,999       999,999      999,999       999,999      999,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                                 999,999       999,999      999,999       999,999      999,999       999,999       9,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

    STATE TOTALS                 999,999       999,999      999,999       999,999      999,999       999,999      999,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                                 999,999       999,999      999,999       999,999      999,999       999,999       9,999
                                9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

                                                                    * * END OF REPORT * *

                                                                    * NO DATA THIS RUN * *
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EPS-0008-M EPSDT Healthwatch Screens Performed Monthly – Medicaid

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-0008-M		EPSDT Healthwatch Screens Performed Monthly – Medicaid

Description of Information

The EPSDT Healthwatch Screens Performed Monthly – Medicaid Report (EPS-0008-M) summarizes by county the number of Medicaid EPSDT recipients eligible for Healthwatch screenings and the number of Medicaid EPSDT recipients actually screened. The report is divided into four age categories: birth through age two years, age three years through age five years, age six years through age 14 years, and age 15 years through age 20 years. The age of the recipient is determined as of the last day of the report period. State totals for each age category are calculated at the end of the report.

Only paid physician claims details (including shadow claims) are considered for inclusion in this report. Screening procedure codes include 99381, 99385, 99391, 99395, 99431, and 99432; as well as 99201 – 99205 and 99211 - 99215 when billed in conjunction with an associated diagnosis code of V20 - V20.2, V700, or V703 – V709.

Purpose

The EPSDT Healthwatch Screens Performed Monthly Report – Medicaid (EPS-0008-M) is used by the State to review the number of Medicaid EPSDT recipients eligible for Healthwatch screenings versus the number of Medicaid EPSDT recipients actually screened.

Sort Sequence

- *Primary* - County
- *Secondary* - Recipient age

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

County Name	The name of the county where the recipient resides at the time the report is generated. This is the primary sort criteria for the report
Age 0 Through Age2	The age range for Medicaid EPSDT recipients from birth through age two years on the last day of the report period.

Age 3 Through Age5	The age range for Medicaid EPSDT recipients from age three years through age five years on the last day of the report period.
Age 6 Through Age 14	The age range for Medicaid EPSDT recipients from age six years through age 14 years on the last day of the report period
Age 15 Through Age 20	The age range for Medicaid EPSDT recipients from age 15 years through age 20 years on the last day of the report period
Number Eligible	The unduplicated number of Medicaid EPSDT eligible recipients within the specified county and age category during the reporting period. This includes recipients through the age of 20 years.
Number Screened	The unduplicated number of Medicaid EPSDT eligible recipients within the specified county and age category who had a paid EPSDT screening during the reporting period. Screenings are defined as occurrences of the procedure code and procedure code and diagnosis code combinations as defined above.
Percent Screened	The percentage of eligible recipients screened for each age group on the report. The field calculation is *Number Screened* divided by *Number Eligible* for each age group.
State Total	The state total of unduplicated Medicaid EPSDT recipients eligible for screenings, actually screened, and the percentage of recipients screened. The *Number Eligible* and *Number Screened* fields are a sum of the counties on the report. The *Percent Screened* fields are calculated from the state totals for number eligible and screened.
Grand Total Eligible	The total unduplicated number of Medicaid EPSDT eligible recipients. This field is a sum of the *Number Eligible* fields for each age group under the state totals row.
Grand Total Screened	The total unduplicated number of Medicaid EPSDT recipients for whom a screening claim paid during the reporting period. This field is a sum of the *Number Screened* fields for each age group under the *State Totals* row.
Grand Percentage Screen	The statewide total percent of recipients screened. The calculation is *Grand Total Screened* divided by *Grand Total Eligible*.

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  REPORT:  EPS-0008-M                                       IndianaAIM                       RUN DATE:  MM/DD/CCYY
  PROCESS:                                                                                        RUN TIME:  MM:HH
  LOCATION:                                           EPSDT HEALTHWATCH SCREENS PERFORMED MONTHLY - MEDICAID  PAGE NUMBER:  99,999
                                                                PERIOD:  MM/DD/YY THROUGH MM/DD/YY

                  AGE 0 THROUGH AGE 2           AGE 3 THROUGH AGE 5          AGE 6 THROUGH AGE 14          AGE 15 THROUGH AGE 20

  COUNTY       NUMBER    NUMBER   PERCENT    NUMBER    NUMBER   PERCENT    NUMBER    NUMBER   PERCENT    NUMBER    NUMBER   PERCENT
   NAME       ELIGIBLE  SCREENED  SCREENED  ELIGIBLE  SCREENED  SCREENED  ELIGIBLE  SCREENED  SCREENED  ELIGIBLE  SCREENED  SCREENED

XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
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XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
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XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999
XXXXXXXXXXX    99,999    99,999     999      99,999    99,999     999      99,999    99,999     999      99,999    99,999     999

STATE TOTAL   999,999   999,999    999%     999,999   999,999    999%     999,999   999,999    999%     999,999   999,999    999%

                     GRAND TOTAL ELIGIBLE:  999,999

                     GRAND TOTAL SCREENED:  999,999

                     GRAND PERCENTAGE SCREENED:  999%
                                                                 * * END OF REPORT * *

                                                               * * NO DATA THIS RUN * *
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EPS-0011-A CMS-416: Annual EPSDT Participation Report

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-0011-A		CMS-416: Annual EPSDT Participation Report

Description of Information

The CMS-416 Annual EPSDT Participation Report provides basic information about Medicaid recipient participation in the child health program. This information is used to assess the effectiveness of the State's EPSDT program by of the number of children, by age group and basis of Medicaid eligibility, who are:

1. Provided child health screening services;
2. Referred for corrective treatment;
3. Receive dental, hearing, and vision assessments

There are fourteen lines on the report that provide data such as recipient counts of eligibles, eligibles who received screenings, participation ratios, and eligibles referred for corrective treatment. The data includes fee-for-service and managed care totals.

The recipient's age reports as age on September 30 of each reporting period. If a child is born after September 30, the child would report in the "Under One Year" age group.

The report period follows the Federal Fiscal calendar year.

Purpose

The CMS-416 report demonstrates the State's achievement of its participant and screening goals. From the completed reports, trend patterns and projections are developed for the State and Federal programs. Based on these trends, decisions and recommendations can be made to ensure that eligible children are given the best possible health care. Report data is also used to respond to congressional and public inquiries.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Annual
FSSA	CRLD/Paper	2	Annual

Detailed Field Definition

CN	The data for recipients in the Categorically Needy category of Medicaid eligibility grouping. All Medicaid eligible recipients age birth through 20 years old are included as EPSDT eligible in the categorically needy grouping.
MN	The data for recipients in the Medically Needy category of Medicaid eligibility grouping. Indiana does not cover EPSDT services for the medically needy population, so no data is reported in this field.
Total	Totals for both Categorically Needy and Medically Needy eligibility groupings for each of the age groups and lines of data appearing on the report.
Total(Column 3)	Displays count totals for the seven recipient age groupings for each line of data appearing on the report.
Age Groups (Columns, 4 through 10)	Display recipient data by Categorically Needy, Medically Needy, and a total of both groups for each line of data appearing on the report, based on the four age groups of under 1 year, 1 to 2 years, 3 to 5 years, 6 to 9 years, 10-14 years, 15-18 years and 19-20 years.
Total Individuals Eligible For EPSDT (Line 1)	Displays the total number of recipients, from birth to age 20 years, determined to be eligible for Medicaid. This number includes only the Categorically Needy, because Medicaid does not distinguish the Medically Needy. An eligible person is reported only once, although he or she may have more than one period of eligibility during the reporting period.
State Periodicity Schedule (Line 2a)	Displays the state-specific values reflecting the average number of annual initial or periodic screening services for individuals in each age group.
Number of Years in Age Group (Line 2b)	A fixed number reflecting the number of years included in each age group.
Annualized State Periodicity Schedule (Line 2c)	Divide **State Periodicity Schedule (2a)** by **Number Of Years In Age Group (2b)**. This is the number of screenings expected for an individual in each age group in one year.
Total Months of Eligibility (Line 3a)	The total months of eligibility for the individuals in **Total Individuals Eligible For EPSDT (1).**
Average Period of Eligibility (Line 3b)	Divide **Total Months of Eligibility (3a)** by **Total Individuals Eligible For EPSDT (1).** Divide the resulting number by 12. This is the portion of the year individuals remain eligible for Medicaid. The formula for calculation is: $\frac{A}{12}$ A = Total number of months eligible for all recipients B = Total number of recipients
Expected Number of Screenings per Eligible (Line 4)	The expected number of screenings per child per year. The field calculation is **Annualized State Periodicity Schedule (2c)** multiplied by **Average Period Of Eligibility (3b)**, for each age group and eligibility category.

Expected Number of Screenings (Line 5)	This is the total screenings expected to be provided. Multiply Expected Number of Screenings per Eligible (4) by Total Individuals Eligible For EPSDT (1).
Total Screens Received (Line 6)	Displays the combined number of initial and periodic EPSDT screening examinations with dates of service during the fiscal year. The sources of data include reports from continuing care providers and claims paid for such screening services. See *Attachment A* for the CPT-4 codes included.
Screening Ratio (Line 7)	This ratio represents the extent to which EPSDT eligibles receive the number of screening services required by the periodicity schedule. This ratio may not be more than 100%. Calculate as **Total Screens Received (6**) divided by **Expected Number of Screenings (5)**.
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen (Line 8)	This is the number of persons who should receive at least one screening. Calculate as follows: use the lesser of 1.0 or **Expected Number of Screenings per Eligible (4)**. Multiply this by **Total Individuals Eligible For EPSDT (1)**
Total Eligibles Receiving at Least One Initial or Periodic Screening (Line 9)	This is the count of unduplicated individuals, including those enrolled in managed care arrangements, who received at least one screening during the year. See *Attachment A* for codes.
Total Eligibles Referred for Corrective Treatment (Line 11)	This is the count of unduplicated individuals, including those enrolled in managed care arrangements, who were scheduled for further services as a result of at least one health problem identified during screening, (including vision and hearing).
Total Eligibles Receiving Any Dental Services (Line 12a)	This is the count of unduplicated individuals receiving **any** dental service (HCPC codes D0100-D9999).
Total Eligibles Receiving Preventative Dental Services (Line 12b)	This is the count of unduplicated individuals receiving preventative dental service (HCPC codes D1000-D1999).
Total Eligibles Receiving Dental Treatment Services (Line 12c)	This is the count of unduplicated individuals receiving dental services (HCPC codes D2000-D9999). **Note that 12b + 12c does <u>not</u> equal 12a.** Also, *unduplicated* applies to each line, so a child could be counted for both for 12a and for 12b.
Total Eligibles Enrolled in Managed Care (Line 13)	For informational purposes only. This is the number enrolled in some form of managed care as of 9/30. These people and their services are included in Lines 1, 6, 8, 11 and 12.
Total Number of Screening Blood Lead Tests (Line 14)	The number of blood lead tests, not including those for people diagnosed or under treatment for lead poisoning. Count only birth to 5 years old. *Attachment A* lists the procedure codes included for calculation on this line.

Attachment A

The data in *Attachment A* includes the procedure codes and criteria used in the CMS-416 report as well as the new screening procedure codes and criteria for EPSDT in the Indiana*AIM* system.

Line 6: Total Screens Received

These include the following paid procedures billed with diagnosis code V20.2 or V70.0 or V70.3-70.9 as a diagnosis on the claim:

99201-99205	99211-99215	
99381	99391	99431
99382	99392	99432
99383	99393	*W6511*
99384	99394	*W6512*
99385	99395	

NOTE: The W6511 and W6512 are considered regardless of diagnosis code.

Line 11: Total Eligibles Referred for Corrective Treatment

The following criteria are used to count eligibles referred for corrective treatment:

The Line 11 criteria in *italics* no longer apply.

- EPSDT eligible recipients with paid initial and periodic screening procedures (99201-99205, 99211-99215, 99381-99385, 99391-99395, 99431 and 99432), that were billed with the Z8 modifier on a CMS-1500 claim form
- The procedure codes W6511 and W6512 billed with modifier Z8 is a possibility.
- Procedure code 36415 when billed with the Z4 (lead screen) modifier in conjunction with one of the following positive diagnosis codes: 984.8, 984.0, 984.9, 984.1.
- Procedure code 36415 when billed with the Z5 (sickle cell screen) modifier in conjunction with one of the following positive diagnosis codes: 282.60, 282.63, 282.69, 282.62, 282.61.
- Procedure code 36415 when billed with the Z6 (iron screen) modifier in conjunction with one of the following positive diagnosis codes: 280.9, 280.8, 280.0, 280.1.
- Procedure code 86580 or 86585 (tuberculosis test) billed in conjunction with one of the following positive diagnosis codes: 010.0, 010.1, 010.8, 010.9.

Lines 12a, b and c: Dental Assessment Procedures

Individuals receiving:	**HCPC Code**		
Any dental service	D0100-D9999	*Z0910*	*Z5151*
Preventative dental service	D1000-D1999		
Treatment dental services	D2000-D9999		

Line 13: Total Eligibles Enrolled in Managed Care

- The PMP table tells us which enrollees are with an MCO.

Line 14: Total number of Screening Blood Lead Tests

- CPT 83655 except with ICD9 of 984.0-.9, E861.5 or E866.0.

Report Example: HCFA-416

REPORT: EPS-0011-A IndianaAIM RUN DATE: 02/07/2000
PROCESS: EPA41603 RUN TIME: 08:52
LOCATION: EPS0011C PAGE 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

State: INDIANA FY: 1999

			Age Groups							
			Total	<1	1-2*	3-5	6-9	10-14	15-18	19-20
1.	Total Individuals Eligible for EPSDT:	CN	70,007	10,001	10,001	10,001	10,001	10,001	10,001	10,001
		MN	0	0	0	0	0	0	0	0
		TOTAL	70,007	10,001	10,001	10,001	10,001	10,001	10,001	10,001
2a.	State Periodicity Schedule		0.00	7.00	4.00	3.00	2.00	3.00	2.00	1.00
2b.	Number of Years in Age Group		0.00	1.00	2.00	3.00	4.00	5.00	4.00	2.00
2c.	Annualized State Periodicity Schedule		0.00	7.00	2.00	1.00	0.50	0.60	0.50	0.50
3a.	Total Months of Eligibility	CN	980,021	110,003	120,003	130,003	140,003	150,003	160,003	170,003
		MN	0	0	0	0	0	0	0	0
		TOTAL	980,021	110,003	120,003	130,003	140,003	150,003	160,003	170,003
3b.	Average Period of Eligibility	CN	0.00	0.92	1.00	1.08	1.16	1.25	1.33	1.41
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	0.92	1.00	1.08	1.16	1.25	1.33	1.41
4.	Expected Number of Screenings per Eligible	CN	0.00	6.44	2.00	1.08	0.59	0.75	0.67	0.71
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	6.44	2.00	1.08	0.59	0.75	0.67	0.71
5.	Expected Number of Screenings	CN	122,413	64,406	20,002	10,801	5,901	7,501	6,701	7,101
		MN	0	0	0	0	0	0	0	0
		TOTAL	122,413	64,406	20,002	10,801	5,901	7,501	6,701	7,101
6.	Total Screens Received	CN	120,916	56,497	42,994	6,666	0	6,666	1,427	6,666
		MN	0	0	0	0	0	0	0	0
		TOTAL	120,916	56,497	42,994	6,666	0	6,666	1,427	6,666
7.	Screening Ratio	CN	0.00	0.88	2.14	0.62	0.00	0.89	0.21	0.94
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	0.88	2.14	0.62	0.00	0.89	0.21	0.94

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

REPORT: EPS-0011-A IndianaAIM RUN DATE: 02/07/2000
PROCESS: EPA41603 RUN TIME: 08:52
LOCATION: EPS0011C PAGE 2

State: INDIANA FY: 1999

			Total	Age Groups <1	1 - 2*	3 - 5	6 - 9	10 - 14	15-18	19-20
8.	Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN	57,207	10,001	10,001	10,001	5,901	7,501	6,701	7,101
		MN	0	0	0	0	0	0	0	0
		TOTAL	57,207	10,001	10,001	10,001	5,901	7,501	6,701	7,101
9.	Total Eligibles Receiving at Least One Initial or Periodic Screen	CN	100,478	19,696	28,081	28,081	11,069	11,069	1,241	1,241
		MN	0	0	0	0	0	0	0	0
		TOTAL	100,478	19,696	28,081	28,081	11,069	11,069	1,241	1,241
10.	PARTICIPANT RATIO	CN	0.00	0.51	0.36	0.36	0.53	0.68	5.40	5.71
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	0.51	0.36	0.36	0.53	0.68	5.40	5.71
11.	Total Eligibles Referred for Corrective Treatment	CN	33,750	1	13	720	11,004	11,005	0	11,007
		MN	0	0	0	0	0	0	0	0
		TOTAL	33,750	1	13	720	11,004	11,005	0	11,007
12a.	Total Eligibles Receiving Any Dental Services	CN	107,267	19,696	28,081	12,103	11,069	12,105	12,106	12,107
		MN	0	0	0	0	0	0	0	0
		TOTAL	107,267	19,696	28,081	12,103	11,069	12,105	12,106	12,107
12b.	Total Eligibles Receiving Preventive Dental Services	CN	96,648	19,682	28,144	12,203	0	12,206	12,206	12,207
		MN	0	0	0	0	0	0	0	0
		TOTAL	96,648	19,682	28,144	12,203	0	12,206	12,206	12,207
12c.	Total Eligibles Receiving Dental Treatment Services	CN	96,998	19,696	28,081	12,303	0	12,305	12,306	12,307
		MN	0	0	0	0	0	0	0	0
		TOTAL	96,998	19,696	28,081	12,303	0	12,305	12,306	12,307
13.	Total Eligibles Enrolled in Managed Care	CN	91,000	13,000	13,000	13,000	13,000	13,000	13,000	13,000
		MN	0	0	0	0	0	0	0	0
		TOTAL	91,000	13,000	13,000	13,000	13,000	13,000	13,000	13,000
14.	Total number of Screening Blood Lead Tests	CN	98,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000
		MN	0	0	0	0	0	0	0	0
		TOTAL	98,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

EPS-1007-Q Vaccines for Children Program Provider Utilization – Package C

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-1007-Q		Vaccines for Children Program Provider Utilization – Package C

Description of Information

The Vaccines for Children Program Provider Utilization Report – Package C (EPS-1007-Q) details the quantity and cost of immunizations provided to children 18 years of age and under. This quarterly report lists the number of vaccinations administered by a particular provider. The report also lists the total dollar amount reimbursed by the Package C program to the provider for vaccine administration only.

Totals per county are listed at the end of the report followed by the statewide totals. Page breaks occur at the end of each county.

Production reporting captures claims paid in a particular quarter and is specific to the quarter analyzed. EPS-1007-Q is scheduled to run at the end of each quarter after the partition of claims paid for that same quarter is compiled.

Purpose

The Vaccines for Children Program Provider Utilization Report – Package C (EPS-1007-Q) is used by the State to ensure utilization requirements are followed by providers.

Sort Sequence

- *Primary* - County
- *Secondary* - Provider

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Quarterly
FSSA	CRLD/Paper	1	Quarterly

Detailed Field Definitions:

County	The name of the county.
Provider Name	The providers last name, first name and middle initial.
Medicaid Number	The provider's Medicaid number.

#90700	The number of dosages of DTAP vaccine administered by the provider. This data is obtained from paid claims submitted by the provider for the monthly reporting period.
$90700	The dollar amount equal to Package C's reimbursement for paid claims for DTAP vaccinations for the monthly reporting period submitted by the provider.
#90721	The number dosages of DTAP/HIB immunizations administered by the provider. This data is obtained from paid claims for the monthly reporting period submitted by the provider.
$90721	The dollar amount equal to Package C's reimbursement for paid claims for the DTAP/HIB vaccinations for the monthly reporting period submitted by the provider.
#90702	The number of dosages of Td/PED immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90702	The dollar amount equal to Package C's reimbursement for paid claims for Td/PED vaccinations for the monthly reporting period submitted by the provider.
#90718	The number of dosages of Td/ADULT (Tetanus & Diphtheria) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90718	The dollar amount equal to Package C's reimbursement for paid claims for Td/ADULT vaccinations for the monthly reporting period submitted by the provider.
#90737	The number of dosages of HIB immunizations administered by the provider. This data is obtained from paid claims for the monthly reporting period submitted by the provider
$90737	The dollar amount equal to Package C's reimbursement for paid claims for HIB vaccinations for the monthly reporting period submitted by the provider.
#90712	The number of dosages of OPV (Oral Polio) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90712	The dollar amount equal to Package C's reimbursement for paid claims for OPV vaccinations for the monthly reporting period submitted by the provider.
#90713	The number of dosages of IPV (Inactivated Polio) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90713	The dollar amount equal to Package C's reimbursement for paid claims for IPV vaccinations for the monthly reporting period submitted by the provider.

#90707	The number of dosages of MMR (Measles, Mumps, Rubella) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90707	The dollar amount equal to Package C's reimbursement for paid claims for MMR (Measles, Mumps, Rubella) vaccinations for the monthly reporting period submitted by the provider.
#90744	The number of dosages of HBP (Hepatitis B Pediatric) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider
$90744	The dollar amount equal to Package C's reimbursement for paid claims for HBP (Hepatitis B Pediatric) vaccinations for the monthly reporting period submitted by the provider.
#90745	The number of dosages of HepB-Adol (Hepatitis B Adolescent/High Risk) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90745	The dollar amount equal to Package C's reimbursement for paid claims for HepB-Adol vaccinations for the monthly reporting period submitted by the provider.
#90716	The number of dosages of Varicella (Chicken Pox) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90716	The dollar amount equal to Package C's reimbursement for paid claims for Varicella (Chicken Pox) vaccinations for the monthly reporting period submitted by the provider.
#90742	The number of dosages of HBIG (Hepatitis B Immune Globulin) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
#90748 Also temporary procedure code Q0158	The number of dosages of Hep B Ped +HIB (Hepatitis B Pediatric and Haemophillus Influenza B) immunizations administered by the provider. This data comes from paid claims for the monthly reporting period submitted by the provider.
$90748 Also temporary procedure code Q0158	The dollar amount equal to Package C's reimbursement for paid claims for Hep B Ped + HIB (Hepatitis B Pediatric & Haemophillus Influenza B) vaccinations for the monthly reporting period submitted by the provider.
County Totals	The total number of VFC Vaccines provided by county and the total dollar amount reimbursed for these vaccines by county.
State Totals	The total number of all VFC vaccines provided by every county and the total dollar amount reimbursed for each VFC vaccines for the state.

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REPORT:   EPS-1007-Q                                   IndianaAIM                              RUN DATE:  MM/DD/CCYY
PROGRAM:  XXXXXXXXX                                                                             RUN TIME:  HH:MM
LOCATION: XXXXXXXXX                    VACCINE FOR CHILDREN PROGRAM – PACKAGE C         PAGE NUMBER:  99,999
                                                   PROVIDER UTILIZATION
                                            PERIOD MM/DD/YY THROUGH MM/DD/YY

COUNTY:   XXXXXXXXXXX

          PROVIDER NAME            #90700     #90702     #90737     #90713     #90744     #90716     #90748
         MEDICAID NUMBER           $90700     $90702     $90737     $90713     $90744     $90716     $90748
                                   #90721     #90718     #90712     #90707     #90745     #90742     #Q0158
                                   $90721     $90718     $90712     $90707     $90745     $90742     $Q0158

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X   9,999      9,999      9,999      9,999      9,999      9,999      9,999
999999999X                                  999,999    999,999    999,999    999,999    999,999    999,999    999,999
                                              9,999      9,999      9,999      9,999      9,999      9,999      9,999
                                            999,999     999,999    999,999   999,999    999,999    999,999  9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X   9,999      9,999      9,999      9,999      9,999      9,999      9,999
999999999X                                  999,999    999,999    999,999    999,999    999,999    999,999    999,999
                                              9,999      9,999      9,999      9,999      9,999      9,999      9,999
                                            999,999     999,999    999,999   999,999    999,999    999,999  9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X   9,999      9,999      9,999      9,999      9,999      9,999      9,999
999999999X                                  999,999    999,999    999,999    999,999    999,999    999,999    999,999
                                              9,999      9,999      9,999      9,999      9,999      9,999      9,999
                                            999,999     999,999    999,999   999,999    999,999    999,999  9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X   9,999      9,999      9,999      9,999      9,999      9,999      9,999
999999999X                                  999,999    999,999    999,999    999,999    999,999    999,999    999,999
                                              9,999      9,999      9,999      9,999      9,999      9,999      9,999
                                            999,999     999,999    999,999   999,999    999,999    999,999  9,999,999

XXXXXXXXXXXXXXXXXXXXXXXXX, XXXXXXXXXXXXX, X   9,999      9,999      9,999      9,999      9,999      9,999      9,999
999999999X                                  999,999    999,999    999,999    999,999    999,999    999,999    999,999
                                              9,999      9,999      9,999      9,999      9,999      9,999      9,999
                                            999,999     999,999    999,999   999,999    999,999    999,999  9,999,999
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REPORT:   EPS-1007-Q                                                      IndianaAIM                       RUN DATE:  MM/DD/CCYY
PROGRAM:  XXXXXXXXX                                                                                             RUN TIME:  HH:MM
LOCATION: XXXXXXXXX                         VACCINE FOR CHILDREN PROGRAM PACKAGE C          PAGE NUMBER:  99,999
                                                                     PROVIDER UTILIZATION
                                                                   COUNTY and STATE TOTALS
                                                               PERIOD MM/DD/YY THROUGH MM/DD/YY

       COUNTY             #90700        #90702       #90737        #90713       #90744        #90716       #90748
                          $90700        $90702       $90737        $90713       $90744        $90716       $90748
                          #90721        #90718       #90712        #90707       #90745        #90742       #Q0158
                          $90721        $90718       $90712        $90707       $90745        $90742       $Q0158

    XXXXXXXXXXX           999,999       999,999      999,999       999,999      999,999       999,999      999,999
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                          999,999       999,999      999,999       999,999      999,999       999,999       9,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

    XXXXXXXXXXX           999,999       999,999      999,999       999,999      999,999       999,999      999,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                          999,999       999,999      999,999       999,999      999,999       999,999       9,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

    XXXXXXXXXXX           999,999       999,999      999,999       999,999      999,999       999,999      999,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                          999,999       999,999      999,999       999,999      999,999       999,999       9,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

    STATE TOTALS          999,999       999,999      999,999       999,999      999,999       999,999      999,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999
                          999,999       999,999      999,999       999,999      999,999       999,999       9,999
                         9,999,999     9,999,999    9,999,999     9,999,999    9,999,999     9,999,999    9,999,999

                                                                     * * END OF REPORT * *

                                                                   * * NO DATA THIS RUN * *
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EPS-1008-M EPSDT Healthwatch Screens Performed Monthly – Package C

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-1008-M		EPSDT Healthwatch Screens Performed Monthly – Package C

Description of Information

The EPSDT Healthwatch Screens Performed Monthly – Package C Report (EPS-1008-M) summarizes by county the number of Package C EPSDT recipients eligible for Healthwatch screenings and the number of Package C EPSDT recipients actually screened. The report is divided into four age categories: birth through 2 years, age 3 years through 5 years, age 6 years through 14 years, and age 15 years through 20 years. The age of the recipient is determined as of the last day of the report period. State totals for each age category are calculated at the end of the report.

Only paid physician claims details (including shadow claims) are considered for the production of this report. Screening procedure codes include 99381, 99385, 99391, 99395, 99431, and 99432 as well as 99201 – 99205, 99211 - 99215 when billed in conjunction with the an associated diagnosis code of V20 - V20.2, V700, V703 - V709.

February 2000 is the first scheduled delivery of the EPSDT Healthwatch Screens Performed Monthly Report – Package C (EPS-1008-M) containing January 2000 data.

Purpose

The EPSDT Healthwatch Screens Performed Monthly Report – Package C (EPS-1008-M) is used by the State to review the number of Package C EPSDT recipients eligible for Healthwatch screenings versus the number of Package C EPSDT recipients actually screened.

Sort Sequence

- *Primary* - County
- *Secondary* - Recipient age

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Monthly
FSSA	CRLD/Paper	1	Monthly

Detailed Field Definitions

County Name — The name of the county where the recipient resides at the time the report is generated. This is the primary sort criteria for the report.

Age 0 Through Age 2	The age range for Package C EPSDT recipients from birth through age two years on the last day of the report period.
Age 3 Through Age 5	The age range for Package C EPSDT recipients from age three years through five years on the last day of the report period.
Age 6 Through Age 14	The age range for Package C EPSDT recipients from age six years through 14 years on the last day of the report period.
Age 15 Through Age 20	The age range for Package C EPSDT recipients from age 15 years through 20 years on the last day of the report period.
Number Eligible	The unduplicated number of Package C EPSDT eligible recipients, within the specified county and age category, during the reporting period. This includes recipients through the age of 20 years.
Number Screened	The unduplicated number of Package C EPSDT eligible recipients, within the specified county and age category, who had a paid EPSDT screening during the reporting period. Screenings are defined as occurrences of the procedure code and procedure code and diagnosis code combinations as defined above.
Percent Screened	The percentage of eligible recipients screened for each age group on the report. The field calculation is Number Screened divided Number Eligible for each age group.
State Total	The state total of Package C EPSDT unduplicated recipients eligible for screenings, actually screened, and the percentage of recipients screened. The Number Eligible And Number Screened fields are a sum of the counties appearing on the report. The Percent Screened fields are calculated from the state totals for number eligible and number screened.
Grand Total Eligible	The total unduplicated number of Package C EPSDT eligible recipients. This field is a sum of the Number Eligible fields for each age group under the state totals row.
Grand Total Screened	The total unduplicated number of Package C EPSDT recipients for whom a screening claim paid during the reporting period. This field is a sum of the Number Screened fields for each age group under the state totals row.
Grand Percentage Screened	The statewide total percentage of recipients screened. The field calculation is Grand Total Screened divided by the Grand Total Eligible.

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  REPORT:  EPS-1008-M                                                        IndianaAIM                             RUN DATE:  MM/DD/CCYY
  PROCESS:                                                                                                               RUN TIME:  MM:HH
  LOCATION:                                          EPSDT HEALTHWATCH SCREENS PERFORMED MONTHLY - PACKAGE C PAGE NUMBER:  99,999
                                                               PERIOD:  MM/DD/YY THROUGH MM/DD/YY

                 AGE 0 THROUGH AGE 2           AGE 3 THROUGH AGE 5           AGE 6 THROUGH AGE 14         AGE 15 THROUGH AGE 20

  COUNTY      NUMBER     NUMBER   PERCENT   NUMBER     NUMBER   PERCENT   NUMBER     NUMBER    PERCENT  NUMBER     NUMBER    PERCENT
   NAME      ELIGIBLE   SCREENED SCREENED  ELIGIBLE   SCREENED SCREENED  ELIGIBLE   SCREENED SCREENED  ELIGIBLE   SCREENED SCREENED

XXXXXXXXXXX   99,999     99,999     999     99,999     99,999     999     99,999     99,999     999     99,999     99,999     999
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XXXXXXXXXXX   99,999     99,999     999     99,999     99,999     999     99,999     99,999     999     99,999     99,999     999
XXXXXXXXXXX   99,999     99,999     999     99,999     99,999     999     99,999     99,999     999     99,999     99,999     999

STATE TOTAL  999,999    999,999     999%   999,999    999,999     999%   999,999    999,999     999%   999,999    999,999     999%

                    GRAND TOTAL ELIGIBLE:  999,999

                    GRAND TOTAL SCREENED:  999,999

                    GRAND PERCENTAGE SCREENED:  999%
                                                                * * END OF REPORT * *

                                                               * * NO DATA THIS RUN * *
```

EPS-1011-A CMS-416C: Annual EPSDT Participation Report for Package C

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-1011-A		CMS-416C: Annual EPSDT Participation Report for Package C

Description of Information

The CMS-416C Annual EPSDT Participation Report provides basic information on participation in the child health program by Package C recipients. This information is used to assess the effectiveness of the State's EPSDT program in terms of the number of children, by age group and basis of Package C eligibility, who are:

1. Provided child health screening services;
2. Referred for corrective treatment;
3. Receive dental, hearing, and vision assessments

There are fourteen lines on the report that provide data such as recipient counts of eligibles, eligibles who received screenings, participation ratios, and eligibles referred for corrective treatment. The data includes fee-for-service and managed care totals.

The recipient's age reports as the age on September 30 of each report period. If a child is born after September 30, the child would report in the "Under One Year" age group.

The report period follows the Federal Fiscal calendar year.

Purpose

The CMS-416C report demonstrates the State's attainment of participant and screening goals. From the completed reports, trend patterns and projections are developed for the State and Federal programs. Based on these trends, decisions and recommendations can be made to ensure that eligible children are given the best possible health care. Report data is also used to respond to congressional and public inquiries.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EDS	CRLD/Paper	1	Annually
FSSA	CRLD/Paper	2	Annually

Detailed Field Definition

CN	Data for recipients in the Categorically Needy of Package C eligibility. All Package C eligible recipients age birth through twenty years are included as EPSDT eligible in the Categorically Needy grouping.
MN	Data for recipients in the Medically Needy of Package C eligibility. Indiana does not cover EPSDT services for the Medically Needy population, so no data is reported in this field.
Total	Displays totals for both *Categorically Needy* and *Medically Needy* eligibility groupings, for each of the age groups and lines of data appearing on the report.
Total (Column 3)	Displays count totals for the seven recipient age groupings, for each line of data appearing on the report.
Age Groups (Columns 4,through 10)	Display recipient data by *Categorically Needy*, *Medically Needy*, and a total of both groups for each line of data appearing on the report, based on the four age groups of under 1 year, 1 to 2 years, 3 to 5 years, 6 to 9 years, 10 to 14 years, 15 to 18 years, and 19 to 20 years.
Total Individuals Eligible For EPSDT (Line 1)	Display the total number of recipients, from birth to age 20, eligible for Package C. This number includes only the *Categorically Needy*, because Package C does not distinguish the *Medically Needy*. An eligible person is reported only once, although he or she may have more than one period of eligibility during the reporting period.
State Periodicity Schedule (Line 2a)	Displays the state-specific values reflecting the average number of annual initial or periodic screening services for individuals in each age group.
Number Of Years in Age Group (Line 2b)	This is a fixed number reflecting the number of years included in each age group.
Annualized State Periodicity Schedule (Line 2c)	Divide **State Periodicity Schedule (2a)** by **Number Of Years In Age Group (2b)**. This is the number of screenings expected to be received by an individual in each age group in one year.
Total Months of Eligibility (Line 3a)	The total months of eligibility for the individuals in **Total Individuals Eligible For EPSDT (1).**
Average Period of Eligibility (Line 3b)	Divide **Total Months of Eligibility (3a)** by **Total Individuals Eligible For EPSDT (1).** Divide that number by 12. This is the portion of the year individuals remain eligible for Package C. **The formula for calculation is: A/B** **12** **A = Total number of months eligible for all recipients** **B = Total number of recipients**
Expected Number of Screenings per Eligible (Line 4)	The expected number of screenings per child per year. The field calculation is **Annualized State Periodicity Schedule (2c)** times **Average Period Of Eligibility (3b)**, for each age group and eligibility category.

Expected Number of Screenings (Line 5)	The total screenings expected to be provided. Multiply Expected Number of Screenings per Eligible (4) by Total Individuals Eligible For EPSDT (1).
Total Screens Received (Line 6)	This field displays the combined number of initial and periodic EPSDT screening examinations with dates of service during the fiscal year. The sources of data include reports from continuing care providers and claims paid for such screening services. Refer to *Attachment A* for the CPT-4 codes included.
Screening Ratio (Line 7)	This ratio represents the extent to which EPSDT eligibles receive the number of screening services required by the periodicity schedule. This ratio may not be over 100%. Calculate as **Total Screens Received (6**) divided by **Expected Number of Screenings (5)**.
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen (Line 8)	This is the number of persons who should receive at least one screening. Calculate as follows: use the lesser of 1.0 or **Expected Number of Screenings per Eligible (4)**. Multiply this by **Total Individuals Eligible For EPSDT (1)**
Total Eligibles Receiving at Least One Initial or Periodic Screen(Line 9)	This is the count of unduplicated individuals, including those enrolled in managed care arrangements, who received at least one screening during the year. Refer *to Attachment A* for codes.
Participant Ratio (Line 10)	This ratio indicates the extent to which eligibles are receiving screening services during the year. Calculate as Total Eligibles Receiving At Least One Initial Or Periodic Screening (9) divided by Total Eligibles Who Should Receive At Least One Initial Or Periodic Screening (8*). (Note - this ratio has been changed per CMS.* See \\DSIBLAN\projdev\PROJECTS\EPSDT\CMS 416 Mods\Line10Reply.txt.)
Total Eligibles Referred for Corrective Treatment (Line 11)	This is the count of unduplicated individuals, including those enrolled in managed care arrangements, who were scheduled for further services as a result of at least one health problem identified during screening, including vision and hearing.
Total Eligibles Receiving Any Dental Services (Line 12a)	This is the count of unduplicated individuals receiving any dental service (HCPC codes D0100-D9999).
Total Eligibles Receiving Preventative Dental Services (Line 12b)	This is the count of unduplicated individuals receiving preventative dental service (HCPC codes D1000-D1999).
Total Eligibles Receiving Dental Treatment Services (Line 12c)	This is the count of unduplicated individuals receiving dental services (HCPC codes D2000-D9999). **Note that 12b + 12c does <u>not</u> equal 12a.** Also, *unduplicated* applies to each line, so a child may be counted for both 12a and for 12b.
Total Eligibles Enrolled in Managed Care (Line 13)	For informational purposes only. This is the number enrolled in some form of managed care as of 9/30. These people and their services are included in Lines 1, 6, 8, 11 and 12.

Total number of Screening Blood Lead Tests (Line 14)	The number of blood lead tests, not including those for people diagnosed or under treatment for lead poisoning. Count only birth to 5 years old. *Attachment A* lists the procedure codes included for calculation on this line.

Attachment A

The data in *Attachment A* includes the procedure codes and criteria used in the CMS-416C report as well as the new screening procedure codes and criteria for EPSDT in the Indiana*AIM* system.

Line 6: Total Screens Received

These include the following paid procedures billed with diagnosis code V20.2 and/or V70.0 and/or V70.3-70.9 as a diagnosis on the claim:

99201-99205	99211-99215	
99381	99391	99431
99382	99392	99432
99383	99393	*W6511*
99384	99394	*W6512*
99385	99395	

NOTE: The W6511 and W6512 are considered regardless of diagnosis code.

Line 11: Eligibles Referred for Corrective Treatment

The following criteria are used to count eligibles referred for corrective treatment:

The Line 11 criteria in *italics* no longer apply.

- EPSDT eligible recipients with paid initial and periodic screening procedures (99201-99205, 99211-99215, 99381-99385, 99391-99395, 99431 or 99432), that were billed with the Z8 modifier on a CMS-1500 claim.
  - The procedure codes W6511 and W6512 billed with modifier Z8 is a possibility.
  - Procedure code 36415 when billed with the Z4 (lead screen) modifier in conjunction with one of the following positive diagnosis codes: 984.8, 984.0, 984.9, 984.1.
  - Procedure code 36415 when billed with the Z5 (sickle cell screen) modifier in conjunction with one of the following positive diagnosis codes: 282.60, 282.63, 282.69, 282.62, 282.61.
  - Procedure code 36415 when billed with the Z6 (iron screen) modifier in conjunction with one of the following positive diagnosis codes: 280.9, 280.8, 280.0, 280.1.
  - Procedure code 86580 or 86585 (tuberculosis test) billed in conjunction with one of the following positive diagnosis codes: 010.0, 010.1, 010.8, 010.9.

Lines 12a, b and c: Dental Assessment Procedures

Individuals receiving:	**HCPC Code**		
Any dental service	D0100-D9999	*Z0910*	*Z5151*
Preventative dental service	D1000-D1999		
Treatment dental services	D2000-D9999		

Line 13: Total Eligibles Enrolled in Managed Care

- The PMP table tells us which enrollees are with an MCO.

Line 14: Total number of Screening Blood Lead Tests

- CPT 83655 except with ICD9 of 984.0 through 984.9, E861.5 or E866.0.

Report Example: HCFA-416C

REPORT: EPS-1011-A IndianaAIM RUN DATE: 02/07/2000
PROCESS: EPA41603 RUN TIME: 08:52
LOCATION: EPS1011C PAGE 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM HCFA-416C: ANNUAL EPSDT PARTICIPATION REPORT

State: INDIANA FY: 1999

			Age Groups							
			Total	<1	1-2*	3-5	6-9	10-14	15-18	19-20
1.	Total Individuals Eligible for EPSDT:	CN	70,007	10,001	10,001	10,001	10,001	10,001	10,001	10,001
		MN	0	0	0	0	0	0	0	0
		TOTAL	70,007	10,001	10,001	10,001	10,001	10,001	10,001	10,001
2a.	State Periodicity Schedule		0.00	7.00	4.00	3.00	2.00	3.00	2.00	1.00
2b.	Number of Years in Age Group		0.00	1.00	2.00	3.00	4.00	5.00	4.00	2.00
2c.	Annualized State Periodicity Schedule		0.00	7.00	2.00	1.00	0.50	0.60	0.50	0.50
3a.	Total Months of Eligibility	CN	980,021	110,003	120,003	130,003	140,003	150,003	160,003	170,003
		MN	0	0	0	0	0	0	0	0
		TOTAL	980,021	110,003	120,003	130,003	140,003	150,003	160,003	170,003
3b.	Average Period of Eligibility	CN	0.00	0.92	1.00	1.08	1.16	1.25	1.33	1.41
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	0.92	1.00	1.08	1.16	1.25	1.33	1.41
4.	Expected Number of Screenings per Eligible	CN	0.00	6.44	2.00	1.08	0.59	0.75	0.67	0.71
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	6.44	2.00	1.08	0.59	0.75	0.67	0.71
5.	Expected Number of Screenings	CN	122,413	64,406	20,002	10,801	5,901	7,501	6,701	7,101
		MN	0	0	0	0	0	0	0	0
		TOTAL	122,413	64,406	20,002	10,801	5,901	7,501	6,701	7,101
6.	Total Screens Received	CN	120,916	56,497	42,994	6,666	0	6,666	1,427	6,666
		MN	0	0	0	0	0	0	0	0
		TOTAL	120,916	56,497	42,994	6,666	0	6,666	1,427	6,666
7.	Screening Ratio	CN	0.00	0.88	2.14	0.62	0.00	0.89	0.21	0.94
		MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
		TOTAL	0.00	0.88	2.14	0.62	0.00	0.89	0.21	0.94

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

REPORT: EPS-1011-A IndianaAIM RUN DATE: 02/07/2000
PROCESS: EPA41603 RUN TIME: 08:52
LOCATION: EPS1011C PAGE 2

State: INDIANA FY: 1999

			Age Groups						
		Total	<1	1 - 2*	3 - 5	6 - 9	10 - 14	15-18	19-20
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN	57,207	10,001	10,001	10,001	5,901	7,501	6,701	7,101
	MN	0	0	0	0	0	0	0	0
	TOTAL	57,207	10,001	10,001	10,001	5,901	7,501	6,701	7,101
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CN	100,478	19,696	28,081	28,081	11,069	11,069	1,241	1,241
	MN	0	0	0	0	0	0	0	0
	TOTAL	100,478	19,696	28,081	28,081	11,069	11,069	1,241	1,241
10. PARTICIPANT RATIO	CN	0.00	0.51	0.36	0.36	0.53	0.68	5.40	5.71
	MN	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	TOTAL	0.00	0.51	0.36	0.36	0.53	0.68	5.40	5.71
11. Total Eligibles Referred for Corrective Treatment	CN	33,750	1	13	720	11,004	11,005	0	11,007
	MN	0	0	0	0	0	0	0	0
	TOTAL	33,750	1	13	720	11,004	11,005	0	11,007
12a. Total Eligibles Receiving Any Dental Services	CN	107,267	19,696	28,081	12,103	11,069	12,105	12,106	12,107
	MN	0	0	0	0	0	0	0	0
	TOTAL	107,267	19,696	28,081	12,103	11,069	12,105	12,106	12,107
12b. Total Eligibles Receiving Preventive Dental Services	CN	96,648	19,682	28,144	12,203	0	12,206	12,206	12,207
	MN	0	0	0	0	0	0	0	0
	TOTAL	96,648	19,682	28,144	12,203	0	12,206	12,206	12,207
12c. Total Eligibles Receiving Dental Treatment Services	CN	96,998	19,696	28,081	12,303	0	12,305	12,306	12,307
	MN	0	0	0	0	0	0	0	0
	TOTAL	96,998	19,696	28,081	12,303	0	12,305	12,306	12,307
13. Total Eligibles Enrolled in Managed Care	CN	91,000	13,000	13,000	13,000	13,000	13,000	13,000	13,000
	MN	0	0	0	0	0	0	0	0
	TOTAL	91,000	13,000	13,000	13,000	13,000	13,000	13,000	13,000
14. Total number of Screening Blood Lead Tests	CN	98,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000
	MN	0	0	0	0	0	0	0	0
	TOTAL	98,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

EPS-9001-M EPSDT Screening Notification Letter

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-9001-M		EPSDT Screening Notification Letter

Description of Information

The EPSDT Screening Notification Letter (EPS-9001-M) is a system - generated letter sent to EPSDT recipients monthly. A letter is sent to each recipient one month prior to the next scheduled screening visit in accordance with the published periodicity schedule. For a newborn, the first letter is generated for the screening required at 12 months of age. The letter details the family help line, the WIC program, the age categories for HealthWatch visits, and the Hoosier HealthWise program.

The recipient's address is printed on the back of the letter so that it may be folded for mailing in a window envelope. A return address for the Department of Family and Children county where the recipient resides is also included on the back of the letter for visibility in the window envelope. If the letter is undeliverable for any reason, it is returned to the county office listed on the letter.

Purpose

The EPSDT Screening Notification Letter (EPS-9001-M) is sent to EPSDT recipients to remind them of their next HealthWatch screening and to encourage participation in the HealthWatch program. The first delivery of this letter is scheduled after the February 1995 month end processing.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EPSDT Recipients	Paper	1	Monthly

Letter Example: Screening Notification

[current date]

Dear Parent or Guardian:

According to our records, you or your child may be due for a HealthWatch checkup. Please ask your doctor if it is time to schedule a HealthWatch checkup.

The HealthWatch program helps children and teens stay healthy through regular checkups, immunizations (shots), and treatment for health problems. HealthWatch helps you watch for and treat health problems before they become serious. Checkups are recommended at these ages:

* 1 month	* 9 months	* 24 months	* 6 years	* 14 years
* 2 months	* 12 months	* 3 years	* 8 years	* 16 years
* 4 months	* 15 months	* 4 years	* 10 years	* 18 years
* 6 months	* 18 months	* 5 years	* 12 years	* 20 years

You may receive HealthWatch services through the Hoosier Healthwise program. For more information about the different Hoosier Healthwise program benefit packages call 1-800-889-9949 (toll free call). Most Hoosier Healthwise benefit packages allow you to:

- Choose your own doctor
- Get medically necessary health care
- Arrange for transportation to health care services (limited to certain benefit packages)
- Get care coordination services for pregnant women (limited to certain benefit packages)

The Indiana Family Helpline can provide you with more information about health care services available in your area. You can phone the Indiana Family Helpline (toll free) at 1-800-433-0746.

Another program that helps families stay healthy is the WIC (Women, Infants and Children) program. WIC provides food vouchers to income-eligible pregnant or breast-feeding women and children up to 5 years old. For more information about the WIC program, call the Indiana Family Helpline at 1-800-433-0746.

EPS-9002-M EPSDT Pregnant Women Notification Letter

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-9002-M		EPSDT Pregnant Women Notification Letter

Description of Information

The EPSDT Pregnant Women Notification Letter (EPS-9002-M) is a system-generated letter sent to pregnant women who are eligible for Indiana Health Coverage Programs because of pregnancy. This category of pregnant women is defined as those in the SOBRA aid category, which includes ICES categories MAE, MAM, MAN, MAP, MAMP, MANP, and MAPP. The letter describes Care Coordination services for pregnant women, the HealthWatch program, the WIC program, and the Hoosier HealthWise program.

The recipient's address is printed on the back of the letter so that it may be folded for mailing in a window envelope. A return address for the Department of Family and Children county where the recipient resides, is also included on the back of the letter for visibility in the window envelope. If the letter is undeliverable for any reason, it is returned to the county office listed on the letter.

The EPSDT Pregnant Women Notification Letter (EPS-9002-M) is sent monthly and each pregnant recipient receives only one notification letter during her pregnancy. The first delivery of these letters is after February 1995 month end processing and includes women who meet the eligibility requirements for the month of February 1995.

Purpose

The EPSDT Pregnant Women Notification Letter (EPS-9002-M) educates EPSDT eligible pregnant women on the Indiana Health Coverage Programs that can provide preventive health care for children from birth up to age 21 (up to age 18 for Package C).

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
SOBRA recipients	Paper	1	Monthly

Letter Example: EPSDT Pregnant Women Notification Letter

[current date]

Dear Mother-To-Be:

Before too long, you will bring a new life into the world. We want you to know about these services that can help you and your baby stay healthy.

Care Coordination Services for Pregnant Women

Ask your doctor about these services.

WIC Program

WIC (which stands for Women, Infants and Children) provides food vouchers to income-eligible pregnant or breast-feeding women and children up to 5 years old. For more information about the WIC program, call the Indiana Family Helpline (toll free) at 1-800-433-0746.

HealthWatch Program

HealthWatch provides free checkups, shots and medical treatment to income-eligible children under 21 years old. Ask your child's doctor about the HealthWatch program.

Hoosier Healthwise Program

Hoosier Healthwise benefit packages cover many health care services for Hoosier families who meet income guidelines. For more information about the different Hoosier Healthwise program benefit packages, call 1-800-889-9949 (toll free call). Most Hoosier Healthwise benefit packages allow you to:

Choose your own doctor

Arrange for transportation to health care services

Get medically necessary health care services related to your pregnancy

Get care coordination services for pregnant women.

Please see your doctor regularly during your pregnancy. After your baby is born, update your and your baby's records with each health care program in which you are enrolled.

EPS-9004-M EPSDT – Newly Eligible EPSDT Recipient Pamphlet

Functional Area	Report Number	Job Name	Report Title
EPSDT	EPS-9004-M		EPSDT – Newly Eligible EPSDT Recipient Pamphlet

Description of Information

The EPSDT Recipient Pamphlet (EPS-9004-M) is used to address a system-generated pamphlet sent to newly eligible EPSDT recipients monthly. The job creates the labels for the addresses of recipients receiving the pamphlet. The pamphlet is printed from a different file. The pamphlet details the immunization schedule, HealthWatch checkup schedule, Family Helpline, and the Hoosier HealthWise Hotline.

The recipient's address is printed on the back of the tri-fold pamphlet. A return address for the Department of Family and Children county where the recipient resides is also included on the pamphlet. If the letter is undeliverable for any reason, it is returned to the county office listed on the letter.

Purpose

The Newly Eligible EPSDT Pamphlet (EPS-9004-M) is sent to EPSDT recipients to remind them of their benefits and to encourage participation in the HealthWatch program.

Sort Sequence

None

Distribution

To	Media	Copies	Frequency
EPSDT Recipients	Paper	1	Monthly

Note: Address information only – no sample attached.